Maternal and Child Health Services
Title V Block Grant

State Narrative for Minnesota

Application for 2010
Annual Report for 2008

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The signed Assurances and Certifications are available upon request from:

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D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

In Minnesota, the opportunity for public input into the MCH planning process is ongoing, utilizing a variety of methods at both the state and local levels. State law (Minnesota Statutes 145.882 subd. 3) distributes two-thirds of the federal MCH Block Grant by formula to local public health agencies (called Community Health Boards (CHBs)) and specifically limits the use of these funds to programs that address MCH and CYSHCN issues.

/2009/ MCH Block Grant funds are allocated to CHBs under the Local Public Health Act of 2003. This legislation (Minnesota Statutes 145A.10, Subd. 5a) requires CHBs to establish local public health priorities based on an assessment of community health needs and assets and every five years report to the Commissioner of Health the local priorities the CHB will address. The prioritization and planning processes require CHBs to "seek public input" into the process. The 2005-2009 planning cycle is a transition period for local public health departments. The assessment and action plans will be completed by December 31, 2009 and the priorities and community engagement summary are due by February 1, 2010. Until this more formal process is implemented we ask CHBs to report annually on how community input was obtained and used in the process of identifying the use of federal Title V block grant funds in their communities. //2009// ***/2010/Community surveys, focus groups, key informant interviews and community forums continue to be primary ways in which local public health agencies engage the community in providing input into MCH activities. Attached is the most recent report (2008), listing the various methods local agencies used to help guide local maternal and child health programs. During this process the gaps in health care services or barriers to health care***

access identified in order of significance to the community was: lack of insurance (88%), transportation (86%), income (68%), basic life needs (55%) and cultural competency of providers (38%). Other barriers identified were the availability of community providers, including mental health providers (86%) and dental providers (79%) followed by chemical health providers (48%) and public health nurses (32%). Almost all local public health agencies reported working on these identified gaps within their communities.//2010//

CHBs reported in 2005, that they primarily used community surveys, focus groups, key informant interviews and community forums to garner public input. /2008/ CHBs reported in 2006, that community surveys, focus groups, key informant interviews and established local Advisory Groups were used to garner public input. One of the most common issues identified by CHBs was the lack of access in their communities to dental services. With over 76 percent of the agencies indicating that they responded by working on addressing this issue during the reporting period. Examples of activities include providing fluoride varnish application at EPSDT and WIC clinics, convening community stakeholder groups to address the issue of dental access, and participating with local dentists in Give Kids a Smile Day. //2008//

Other opportunities for community input occur at public hearings when annual budgets for public health activities are reviewed and approved and though dialogue at either Maternal and Child Health or Public Health community advisory groups.

The Maternal and Child Health Advisory Task Force (MCHATF) provides a particularly significant source of input. This statutorily required advisory group, comprised of 15 members equally representing professionals, representatives from local public health, and consumer representatives, is charged with reviewing and reporting on the health care needs of Minnesota's mothers and children and recommending priorities for funding and activities. The Task Force played a key role in the 2005 MCH Needs Assessment. /2009/ The MCHATF continues to play a significant role in providing input into state MCH block grant activities and in the development of strategies and priorities based on the work of the Needs Assessment. //2009//

The MCH block grant application and annual plan is available on the Minnesota Department of Health website for review by the general public.
An attachment is included in this section.

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

The following is one example of taking the needs assessment to the next step. The following specifically targets state priority 9 - Eliminate racial and ethnic health disparities impacting mothers and children.

The Maternal and Child Health Advisory Task Force (MCHATF), a statutory directed advisory group, has been in existence since 1982 providing recommendations to the Commissioner of Health on the needs of Minnesota's maternal and child health population. The duties of the 15 member commissioner appointed task force are set out in Minnesota Statute section 145.881, and include advising the Commissioner of Health on 1) the health care needs of mothers and children 2) the type, frequency, and impact of maternal and child health services in the state; and 3) priorities for funding maternal and child health services.

The MCHATF played a key role in guiding the 2005 needs assessment process and in the identification of Minnesota's ten new state priorities. Using data from the needs assessment they went on to identify specific strategies to be used to address the ten state identified priority areas. Called "Monitoring Trends in Maternal and Child Health: Report and Recommendations of the Maternal and Child Health Task Force", the document was completed and sent to the Commissioner of Health in December 2006.

In responding to the report the Commissioner specifically highlights one of the priorities identified in the report "reducing infant mortality. While progress has been made in the last several years, African American and American Indian infant mortality rates continue to be more than double that for whites. The Department of Health through the Office of Minority and Multicultural Health has been directed by the state legislature to work specifically on the issue of reducing disparities in infant mortality rates between white and racial and ethnic communities. The goal outlined in legislation is "...by 2010, to decrease by 50 percent the disparities in infant mortality rates... for American Indians, and populations of color, as compared with rates for whites." While progress has been made, there continues to be significant disparities between African Americans and American Indian infant mortality rates compared to whites. Because of the importance of this issue, the Commissioner of Health requested that the MCHATF work with the Office of Minority and Multicultural Health and their Advisory Group to recommend strategies and next steps that would allow Minnesota to fully meet the goal of reducing the gap in infant mortality rates by 50 percent by the year 2010.

At the same time the Bureau of Community and Family Health Promotion which is comprised of the Divisions of Community and Family Health; Health Promotion and Chronic Disease; and the Office of Minority and Multicultural Health identified infant mortality as a joint work plan area for the coming year. Significant resources from these three Divisions will come to bear on this issue and ultimately allow Minnesota to meet its goal.

/2009/ The MCH Advisory Task Force convened an Infant Mortality Work Group in early 2008. The purpose of the work group was to review the recommendations on reducing infant mortality originally outlined in the "Monitoring Trends in Maternal and Child Health Report (December 2006)". Members of the work group represented individuals and organizations with a range of expertise and interest in reducing infant mortality, including staff from the Office of Minority and Multicultural Health. The work group indentifed action steps, based on the recommendations in

the original report, that should be taken by MDH and other partners to reduce infant mortality. The Infant Mortality Work Group will continue to meet periodically to review new information and data regarding infant mortality. The group will monitor the status of the proposed action steps and make the full MCH Advisory Task Force membership aware of information and studies of interest.//2009//

/2010/ The Minnesota Department of Health is in the process of conducting the 2010 Title V needs assessment. The proposed process has been reviewed and approved by the MCH Advisory Task Force and MDH administration. To assure a comprehensive needs assessment process, the MDH intends to undertake a series of steps: 1) Engage stakeholders in the needs assessment process (through an online needs survey and needs assessment retreat); 2) Assess the needs of the three target populations through the use of data and broad input from stakeholders; 3) Examine Minnesota's strengths and capacity to address the identified needs; 4) Select up to 10 priorities for Minnesota to address over the next 5 years; 5) Develop an action plan to achieve the identified priorities; 6) Develop measures to monitor the state's performance in addressing those priorities; and 7) Report back to stakeholders annually on Minnesota's progress. The outcome of these activities will be fully documented in the needs assessment submitted in 2010.//2010//

III. State Overview

A. Overview

Minnesota is seen as a state where the people enjoy a high quality of life and experience generally better measures of health compared to most other states. Minnesota consistently ranks as one of the most desirable and healthy states in which to live and work. When parents are asked about the overall health status of their child, 90.4% report that it is excellent or very good (compared to 84.1% nationally). Seventy-eight percent of Minnesota's children have mothers in the work force compared to 69 percent nationally--which may be related to the fact Minnesota has the highest percent (25.6%) of children ages 6 to 11 who stayed home alone. Minnesotans are engaged in their communities; the voter turnout in Minnesota for the 2004 elections was the highest in the nation.

Minnesota is however experiencing the same pressing economic challenges being felt across the country. The 2003 legislative session opened facing a $4.5 billion shortfall, which was resolved primarily with program cuts -- many of which settled heavily on maternal and child populations. Minnesota's publicly funded health insurance programs such as Medical Assistance and MinnesotaCare, its TANF program, local public health funding, and state's social services programs either had reductions in budget or changes in eligibility criteria - most set to begin July 1, 2003. The most recent 2005 legislative session opened facing an additional $466 million budget deficit. The legislature is in an extended session working to make painful choices and decisions. /2007/ The 2006 Legislative session however, saw a slight improvement in the economic picture with an available small surplus. It is expected that Minnesota will also enter the 2007 Legislative session with a small surplus. //2007// /2008/ Minnesota entered the 2007 legislative session with a billion dollar surplus as well as an equal amount available in one time funding for the biennium. //2008// /2009/ Minnesota again experienced the same economic pressures experienced throughout the country. The 2008 legislative session needed to respond to a $935 million shortfall for state fiscal year 2009 and it is anticipated that for biennial budget years 2010 and 2011 the state will need to react during the 2009 legislative session to a significantly higher anticipated shortfall. //2009// ***/2010/The Legislature and the Governor could not agree on how to respond to a projected $2.676 billion dollar biennial 2010-2011 budget shortfall. Despite objections from the Legislature, the Governor decided to resolve the budget gap through the use of executive actions called unallotment and other administrative actions such as payment deferrals. Funding for K-12 education, public safety, military and veterans were protected. As much as possible reductions were weighted toward the second year of the two year budget period to allow the Legislature an opportunity to consider alternatives during the next legislative session. While the Department of Health experienced an administrative reduction, programs were not significantly impacted. Of particular concern is the $100 million loss in local aids to counties and cities in sfy 2010 and $200 million reduction scheduled for sfy 2011 as these funds put further pressures on local public health departments and the work they do. Another area of concern is the $236 million reduction in a variety of human services including reducing grants to counties for mental health services, chemical dependency treatment, housing and other emergency services, and child support administrative costs. Of particular concern to children and adults with disabilities is the lowering of the minimal number of hours of Personal Care Attendant services from 310 to 275 per month. //2010//***

Demographics Minnesota is a medium-sized state, encompassing slightly more than 84,000 square miles. Minnesota's per capita income in 2003 was $34,039, the eighth highest in the country. The 2003 unemployment rate was 5% compared to the national rate of 6%. ***/2010/ While still lower than national rate of 9.4 percent, the Minnesota unemployment rate has edged up to 8.2 in May of 2009. //2010//*** While it remains a major agricultural producer, Minnesota's economy is also driven by service sector industries such as healthcare, manufacturing, financing, insurance, real estate, and wholesale and retail trade. The workforce sustaining this economy comes from a population (2000 Census) count of 4,919,479 people,

making Minnesota the 21st most populous state in the nation. Fifty-four percent of the states residents live in the seven-county, Minneapolis-St. Paul metropolitan area. Minnesota has seven metropolitan statistical areas (MSAs) where seventy percent of the population lives. 65 percent of the statewide population increase of 544,380 that occurred between 1990 and 2000 took place in this seven-county Twin Cities area. American Indians comprise a significant proportion of the population and cultural heritage of Minnesota. According to the 2000 US Census, 58,192 American Indian or Alaska Natives lived in the state, of these, 32,029 were children. In 2000, approximately half of the American Indian population lived on seven Chippewa and four Dakota reservations, while the remainder lived in major population centers and communities spread across the state.

/2009/ According to 2006 population estimates, Minnesota residents are becoming increasingly more diverse statewide. However, there are distinct differences in the location of racial and ethnic subpopulations throughout the state. The metropolitan area, a seven-county region containing Minneapolis and St. Paul, shows the most diversity and the lowest percentage of White residents (85.1%), with 8.1% Black, 5.8% Asian, and 1.0% American Indian. In addition, more than two-thirds (68.5%) of the Hispanic population in MN (N=196,135) resides in the metro area.

The northwest (NW) section of the state has the second lowest proportion of White residents (90.7%), largely because it has the highest percentage of American Indians in MN (7.9%). Primary base of this sizeable Indian population (n=15,720) is three large Ojibway reservations located in the remote northern area. However, NW has little overall racial diversification, with less than one percent each of Blacks (0.6%) and Asians (0.7%) and only 2.0% of the state's Hispanic population. All other regions of the state show a White population of 95% or greater. The central region from east to west has the highest combined proportion of White residents (97.6%, west; 96.4%, east), with all other races either at or just below 1%. East central differs from west central only in its Hispanic population, which comprises 5.8% (n=11,289) of Hispanics in MN, the third largest concentration of this ethnic group outside the metro area.

Northeast (NE), southeast (SE) and southwest (SW) Minnesota reflect minimal racial diversification (95.1 -- 97.1 % White). American Indians (2.9%) own and operate three small reservations in the NE forest areas; however, very few Asians (< 1%), Blacks (1%) or Hispanics (1.4%) live in the northern tier of the state. In contrast, SE and SW have seen a modest expansion in their non-White population and a large increase in their Hispanic population. SW is home to the second largest group of Hispanics (11.5%) living in Minnesota, while SE has an additional 9.0%. Primary reason for these substantial numbers of Hispanics, as well as some African-born Blacks (e.g., Somalis) and Asians (6.8%, combined) is the location of large canneries and meat-packing plants in the southern one-third of the state. Jobs are plentiful and do not require fluent English. Also, many Hispanics were originally seasonal workers on local SW farms and became permanent residents when year-round factory jobs became available.//2009//

Minnesota's population is aging. Overall, Minnesota's age distribution is similar to the national average, but there were some marked differences in age group trends between Minnesota and the U.S. between 1990 and 2000. The median age of Minnesota is 35.4 and the United States median age is 35.3. Minnesota's median age is expected to rise to 41.3 by 2025. The elderly population grew much slower in Minnesota than nationally. The under 10 population also grew less in Minnesota than in the nation. The under-5 population showed a 7 percent gain in the U.S., while falling 2 percent in Minnesota. The 5-to-9 group went up 14 percent nationally but only rose 3 percent in Minnesota. In contrast, Minnesota had stronger than average growth in almost every age group from 15 to 64. The biggest difference was among 15 to 19 year-olds. This population went up 26 percent in Minnesota, much higher than the 14 percent gain nationally .

Demographically, Minnesota had a relatively homogenous racial and ethnic population for most of the twentieth century. This is changing, and although the absolute numbers of populations of color are small, the rate of change is not. In 2000, Populations of Color represented 10.6 percent of the total population in Minnesota as compared to 5.6 percent in 1990. By 2025 it is estimated

that non-White population will represent 17 percent of the State's population . Between 2005 and 2015, the nonwhite population is projected to grow 35 percent, compared to 7 percent for the white population. The Hispanic Origin population is expected to increase 47 percent.

Minnesota's immigrant populations continue to increase. In the late 1970's Minnesota began to see a new wave of international immigration. Following the end of the war in Vietnam, large numbers of refugees from Southeast Asia began to arrive in Minnesota. After the fall of the Soviet Union in 1991, an increased number of refugees came from Eastern Europe. The hostilities in Bosnia-Herzegovina brought more refugees from what was Yugoslavia. Famine and civil war bring large numbers of refugees from Africa. Minnesota's non-profit organizations are welcoming and provide needed services and support to these newcomers, and Minnesota has become a prime destination for refugees. During this same period of time, immigrants came to Minnesota to work in high tech industries. Large numbers of people came from India, China, and Pakistan. These well-educated and well-trained immigrants were hired in the 1990's by the booming technological companies throughout the state. ***/2010/ In the seven county metro area in 2007, more than 125,000 residents were Latino, nearly 45,000 were Hmong, and an estimated 30,000 were Somali. St. Paul has the largest urban Hmong concentration in the world. Minnesota has the largest Somali population in the United States, most of them in Minneapolis. More than 80 languages are spoken in the Twin Cities. //2010//***

In the most recent data (federal fiscal year 2002) from the Office of Immigration Statistics, 13,522 immigrants came to Minnesota from 160 different countries and every continent except Antarctica. Minnesota's major immigrant populations include: Latinos, Hmong, Somalis, Vietnamese, Russians, Laotians, Cambodians and Ethiopians. Many immigrants come here from other states. The effects on Minnesota have been far reaching with visible changes in small towns and cities, schools and businesses. These eight national origin, ethnic or language groups noted above each represent more than 1,000 children in Minnesota's schools in the 2003-2004 school year. As an example, in the town of Pelican Rapids, with a population of 1,900, there are now 24 languages spoken. ***/2010/ By 2007, it is estimated that nearly 38 percent of foreign-born Minnesotans were Asian, 25 percent were Latino, 14 percent were European, 4 percent were Canadian and 19 percent were African. //2010//***

These significant demographic changes such as the aging of its population, concentration of various populations in its metropolitan areas, and rising dependency ratios (elderly and children as a ratio to the working-age population) will impact not only the need for and the type of healthcare, but will also affect housing, education, business, commerce, employers and social services.

Economics - Poverty In Minnesota there are 718,474 families with related children under 18 years, with 1,186,982 children. Eight percent of children live in poor families, compared to the national percent of 17%. Twenty-four percent of children live in low-income families, compared to 38 % nationally. ***/2010/ By 2007, 11.9 percent of Minnesota children lived in poverty compared to 18 percent nationally. //2010//*** Fifty-six percent of these children have at least one parent who is employed full-time annually. Only 9% of children in low-income families do not have an employed parent. The number of children eligible for the free/reduced price school lunch has been increasing, from 24.7% in 1992-1993, to 26.4% in 1996-1997, to 28.5 % in 2001-2002. WIC enrollment has been increasing steadily over the past several years. April enrollments for the past 3 years have grown from 111,717 in 2003, to 116,308 in 2004, to 123,643 in 2005. /2008/ WIC participation in May of 2007 was at an all time high of 135,246 women and children. //2008// /2009/ Continuing to act as a indicator of the state's economic pressures, WIC participation has hit an all time high of 141,864 participants in May 2008. //2009//

Health Disparities While Minnesota enjoys a high level of health status indicators overall, there are significant and highly concerning disparities in health status measures for populations of color and American Indians -- particularly in outcomes related to women and infants. Because the health status of mothers and infants is highly affected by the social conditions in which they live, it

is also important to make note, at least generally, of some of these key indicators, which all show disparities to the disadvantage of populations of color and American Indians. Table 1 provides an overview of some of these social condition indicators. (See attached Table 1).

In 2003 the self-identified racial composition of women who gave birth was mostly white (84%). The remaining 16% of the women who gave birth self-identified as African American (7.6%), Asian (5.5%), and American Indian (2.0%). /2008/ In 2005, the self-identified racial composition of women who gave birth continued to be moslty white (82%). The remaining 18% of women self-identified as African American (8.9%), Asian (6.6%), and American Indian (2%). //2008// The birth rate per 1000 teens 15-19 years old for 2001 -- 2003 varied by race as follows: African-American 122.1; American Indian 112.4; Asian 67.9; Hispanic 129.8; and White 29.4 . /2008/ While progress has been made in the rates of teen births, significant disparities still persist (2004 data: African American (71.1); American Indian (93.6); Asian (47.8) and White (17.3). //2008// According to 1997-2001 Minnesota birth certificate data, rates of inadequate/no prenatal care are three to four times higher among populations of color in Minnesota (African Americans (12.4%), American Indian (17.4%), Asian (9.8%), and Hispanic (11.2%) compared to such rates for white pregnant women (3.2%). /2009/ Compared to 1997-2001, data from 2001-2005 indicate rates of women receiving inadequate or no prenatal care have decreased for all populations in Minnesota, African Americans (9.0 percent), American Indian (15.9 percent), Asian (6.1 percent), Hispanic (8.4 percent), and white (2.6 percent). However, significant disparities continue to exist with American Indian women six times more likely to receive inadequate care or no care during their pregnancies than white women. //2009//

Between the time periods 1989-1993 and 1997-2001, the percent of premature births decreased in all racial/ethnic groups except for White, which increased slightly. However disparities still exist so that approximately 1 of 10 African American, American Indian and Asian babies are born premature compared to 1 in 14 White and Hispanic babies. The change in low birth weight (under 2500 grams) from 1989-1993 to 1997-2001 have been less than one percent for all racial and ethnic groups except African Americans, where the LBW decreased from 11.5 to 9.1 percent. This is still the highest disparity in comparison to low birth weights for American Indians at 5.8 percent, Asians at 6.4 percent, Hispanics at 4.8 percent, and Whites at 4.0 percent. /2009/ Between the time periods 2001-2005 African Americans were the only group to experience a noticeable decline in low birth weight, but at 8.2 percent still remain two times greater than for whites. //2009//

Mortality rates for infants and mothers differ greatly by race and ethnicity. Based on 1996-2000 data neonatal mortality rates (deaths that occur before the 28th day of life) are particularly disparate between African Americans (8.5/1,000), American Indians (6.2/1,000) and whites (3.4/1,000). In other words, African American neonates are 2.5 times more likely and American Indian neonates are 1.8 times more likely to die than their white counterparts. In Minnesota, American Indian (5.7/1,000) and African American infants (4.2/1,000) suffer much higher rates of postneonatal mortality (deaths that occur from 28 to 365 days of life) compared to White infants (1.7/1,000). /2009/ Based on 2000-2004 data, infant mortality rates for African Americans (9.5/1,000) and American Indians (10.2/1,000) have decreased over time but continue at more than two times that for whites (4.5/1,000). //2009// ***/2010/ Significant reductions in infant mortality rates for Asian (7.1 per 1,000 births in 1995-1999 to 4.8 per 1,000 births in 2001-2005) and Hispanics (7.0 per 1,000 births in 1995-1999 to 4.9 per 1,000 births in 2001-2005) have occurred over time, and are now close to the 2001-2005 White rate of 4.4 per 1,000 //2010//***

Maternal mortality rates are based on women who die while pregnant or within one year of termination of pregnancy, irrespective of cause. Based on 1990-1999 data, African American women died of pregnancy-associated issues at a rate 2.4 times higher than the white rate. The American Indian women's pregnancy-associated death rate was 2.8 times the white rate. /2008/ Data from 2000-2004 indicate these disparities continue to persist. //2008//

Insurance - Access Minnesota continues to maintain one of the lowest rates of uninsured populations in the nation. Some recent information however is showing some potentially negative changes in those rates. Based on the 2004 Minnesota Health Access Survey, there is a general increase in uninsured Minnesotan's (from 5.4% in 2001 to 6.7% in 2004). This increase was driven by a decrease in employer-based health insurance coverage, a shift in Minnesota's income distribution, and a change in Minnesota's Hispanic/Latino population. In 2004, Minnesotans were more likely to be uninsured or covered by public health insurance programs and less likely to be covered by group or employer-based health insurance coverage than they were in 2001. Rates of uninsured continue to show disparities based on race, with the change being most pronounced for Hispanic/Latino Minnesotans. /2009/ After rising between 2001 and 2004, the percentage of Minnesotans without health insurance was stable between 2004 and 2007 (2007 Minnesota Health Access Survey). An estimated 7.2 percent of Minnesotans, or about 374,000 people, were uninsured in 2007. The rate of uninsurance in 2007 was statistically unchanged from 2004 when it was 7.7 percent. An estimated 4.8 million Minnesotans have health insurance through an employer, public program or individual purchased coverage. National surveys, although not directly comparable to this study, show that Minnesota has the lowest uninsurance rate in the nation. //2009//

Results from the Minnesota Health Access Survey of 2004 show some significant changes between 2001 and 2004 of insured rates for women and children. Between 2001 and 2004 uninsured rates increased for all children (birth-17) from 6.4% to 7.7%. In the Black population (birth-17) uninsured rates decreased from 16.9% to 12.4 %, but this is still double the White rate of 6.4%. The overall non-White uninsured rate for 2004 is 16.0% with Hispanic being highest at 31.6 % (up from 19.7% in 2001).

Within the birth to 5 year old group, the uninsured rate rose from 5.7% in 2001 to 9.2% in 2004. The non-White rate remained relatively stable, while the White rate increased from 4.2% to 8.0%. This Birth to 5 year old uninsured rate is higher than the overall uninsured rates for the 6-12 age group (7.0%) and the 13-17 age group (7.1%). It is too early to tell whether these rates may have been influenced by policy changes from the 2003 legislative session, which went into effect on 7/1/2003. The Children's Defense Fund of Minnesota estimated these policy changes would negatively impact the insurance status for 20,000 children.

This study also indicated that rates of uninsurance for women in the childbearing years (15-44) increased from 11.5% to 12.8% overall. Table 2 describes these changes for women. (See attached Table 2).

State funded health programs in Minnesota provided health insurance coverage for roughly 654,000 state residents at some point during state fiscal year 2004 through it's three publicly funded basic health care programs -- Medical Assistance (Minnesota's Medicaid program), General Assistance Medical Care (GAMC), and MinnesotaCare. /2008/ Approximately 662,000 Minnesotans received health care through the state's three publicly funded health care programs during state fiscal year 2006. //2008// The Minnesota Department of Human Services (DHS) administers MinnesotaCare and oversees MA and GAMC, administered by counties. About 70 percent of DHS's budget is devoted to these three programs. About half of enrollees in all programs combined are children under 21. /2007/ During the 2006 Legislative session, a pay-for-performance system for publicly funded health care programs was approved. Minnesota will be the first state in the nation to participate in a pay-for-performance protocol known as Bridges to Excellence for diabetes management in state health plans. //2007// /2008/ Minnesota's pay for performance system, called QCare, that rewarded providers for optimum client care for diabetes was expanded during the 2007 legislative session to include cardiac disease. //2008//

Medical Assistance (MA) Medical Assistance is the state's Medicaid program and provides acute, chronic and long-term care services to low-income seniors, children and families, and people with disabilities. Families, children and pregnant women account for 69 percent of Minnesota's MA enrollees, but account for only 22 percent of its expenditures. The majority of

expenditures, more than 78 percent, are for people who are elderly or have a disability. /2008/ Children, parents and pregnant women make up the largest Medicaid group (70 percent), but account for only 25 percent of expenditures. The remaining 75 percent of expenditures are for people who are elderly or have a disability. //2008// Program expenditures for state fiscal year 2004 totaled $4.99 billion, of which the federal share was $2.63 billion. MA provided coverage for a monthly average of $464,000 in FY 2004. The average monthly enrollment of children was 321,291. /2009/ Efforts the past two legislative sessions have been directed on assuring all children eligible for public programs are enrolled. One of these initiatives is called Community Application Agent Program. This program 1) provides a bonus of $20 to an organization who successfully enrolls a child on Medicaid, 2) requires the state to provide a toll free number to provide information on public and private health coverage options and sources of free and low cost health care, 3) requires a number of public programs to have applications available for Minnesota's health care programs and to provide direct assistance in completing the application form or provide information on where an applicant can receive application assistance, and 4) requires school districts to provide information to each student on the availability of health care coverage and to provide children determined eligible for free or reduced priced lunch with application assistance. //2009// ***/2010/ In January 2009, 635,838 families and children, 133,799 disabled persons, and 63,267 elderly persons were enrolled on Medical Assistance. //2010//***

The state currently operates its Medicaid program with one Section 1915(a) waiver, one Section 1915(b) freedom of choice waiver, six Section 1915(c) home and community-based waivers, and Section 1115 waivers. The Section 1115 waiver is the state's MinnesotaCare Health Care Reform Waiver. The TEFRA waiver allows some children with disabilities who live with their families to be eligible for Medical Assistance without counting parent's income. Also the Home and Community Based Waiver programs allow some children with disabilities who live with their families to be eligible for Medical Assistance without counting the parent's income. Medical Assistance for Employed Persons with Disabilities allows working children with disabilities who are at least 16 to quality for Medical Assistance under a higher income limit.

The central Medicaid 1115 waiver is the state's PMAP waiver. The Prepaid Medical Assistance Program (PMAP) began in 1982 when Minnesota was selected by the federal Health Care Financing Administration (HCFA) as one of five original states to implement managed care for non long-term care services for designated Medicaid populations on a prepaid, capitated basis. Populations covered by the now statewide PMAP program include families with children, elderly, children in foster care placement, and on a voluntary basis, children eligible for MA through subsidized adoptions, and children who are seriously emotionally disturbed and who are eligible for MA-covered targeted case management. There is federal financial participation for coverage of pregnant women and children in the MinnesotaCare program (described later in this section). As of December 2004, 83 of Minnesota's 87 counties were participating in the PMAP+ program. A 1997 state law authorized all counties to choose the type of Medicaid managed care model to be implemented in their county: either PMAP or County-Based Purchasing. County-based purchasing would allow counties (instead of the state) to purchase and/or provide comprehensive Medicaid services on a risk basis contingent upon federal 1115 waiver approval.

Minnesota has received approval for an 1115 waiver demonstration project for family planning that is being planned for implementation on July 1, 2006. /2007/ Waiver implementation was delayed one year due to systems issues. When fully implemented the waiver is expected to serve 50,000 individuals between the ages of 15 and 50. //2007// This will provide eligibility for family planning services, including treatment for STIs identified in a family planning visit, to women and men at or below 200% FPG and provide automatic extension of family planning coverage for one year to anyone who loses MA or MinnesotaCare coverage. /2009/ In state fiscal year 2007, the program served about 26,000 people with total expenditures of approximately $4.3 million. //2009//

/2010/ Almost 34,000 individuals were served in 2008 with 39,000 individuals projected to receive services in 2011. //2010//

MinnesotaCare is a state subsidized managed care program funded by a tax on hospitals and health care providers, federal Medicaid matching funds, and enrollee premiums and co-payments. Medical payments for MinnesotaCare totaled $487 million in FY 2004, with average medical payments per enrollee of $273 a month. The average monthly MinnesotaCare enrollment in 2004 was 148,000. Families with children are eligible for the program on a sliding-fee scale if their family is income and asset eligible. There is no asset limit for pregnant women or children. Federal financial participation is claimed for pregnant women and for children and benefits for these two populations are the same as those provided for under the Medical Assistance (Medicaid) program. Federal financial participation is also claimed for parents and relative caretakers enrolled in MinnesotaCare. /2009/ MinnesotaCare enrollment in state fiscal year 2007 was 117,893 with approximately $434 million expended for care during that year. During the 2008 legislative session eligibility and outreach were expanded and sliding-fee premiums for MinnesotaCare were reduced. Other provisions made the renewal process for staying on MinnestoaCare easier for enrollees. //2009// ***/2010/ In May 2009, 120,929 individuals were on MinnesotaCare with 69,076 representing individuals in families with children. //2010//***

Erosion or crowd-out barriers consist of essentially three eligibility provisions. First, children, families and pregnant women must be permanent residents; families without children must not only be permanent residents, but also must have resided in the state for six months prior to enrollment. Second, individuals cannot have had other health coverage for four months prior to enrollment except for children in families with income at or less than 150 percent of FPG or for individuals making a transition to MinnesotaCare from MA or GAMC. The third eligibility provision denies, with certain exceptions, eligibility for individuals who have had access to employer subsidized insurance (50 percent or more of premium cost) through a current employer in the 18 month period prior to enrollment in the MinnesotaCare program. In response to the state's budget deficit, a more limited benefit set was established for adults without children. As a budget reduction strategy, effective 10/1/03 benefits limitations were added to hospitalization, physicians, drugs, outpatient services and lab/diagnostic services. A $10,000 limit on hospital care with a 10 percent co-pay requirement was added. In addition, premiums were increased for all populations using the program.

General Assistance Medical Care (GAMC) GAMC is a state funded program that covers acute care services for residents not categorically eligible for MA but who meet income and asset standards comparable to the medically needy standards of the MA program. The program provides coverage for most, but not all, of the same health services offered by the MA program. Individuals who may be eligible include adults with no dependent children, adults residing in group resident housing, adults awaiting a determination of disability, and adults participating in the state's General Assistance program. In 2004, GAMC provided medical care for a monthly average of 34,900 low-income Minnesotans - primarily low-income adults, ages 21-64, who have no dependent children. Expenditures in FY 2004 were $245.6 million, with average medical payment for a GAMC enrollee of $587 a month. As part of the state's response to the budget deficits of the last few years, effective 10/1/03 eligibility for GAMC was lowered from 175 % of federal poverty level (FPL) to 75 % of FPL. A new "catastrophic" health program for individuals between 75 % of FPL and 175 % of FPL was established but, to cover hospitalization costs only and includes a $1,000 deductible. ***/2010/ Due to the significant budget shortfall projected for state fiscal year 2010, GAMC, which serves approximately 30,000 adults without children will be eliminated in March of 2010. It is expected that some of the individuals receiving GAMC will be able to transition to MinnesotaCare, however, it is anticipated that a number of individuals will not be able to make the transition for various reasons. It was projected that GAMC costs would exceed $380 million in state fiscal year 2010. //2010//***

In response to the severe budget shortfalls, changes were made in the 2003 and 2004 Legislative sessions to these public health care programs that have had a significant impact on mothers, children and children with special health care needs. Beginning July 1, 2003, parental fees for

children on the TEFRA waiver program were increased -- in some cases by more than 1,000%; waiver slots for MR/RC, TBI, CADI were reduced or capped; and services to adults were modified, requiring co-pays for drugs, doctor visits and non-emergency emergency room visits while dental care was limited to $500 per year. Beginning July 1, 2004, Medical Assistance income eligibility for pregnant women went from 275 % of FPL to 200 % of FPL, and MA income eligibility for children ages 2 through 18 was lowered from 170 % FPL to 150 % FPL. /2007/ Income eligibility (FPL) changes for Medicaid eligibility were never fully implmented //2007// Infants born to mothers on MA now qualify for one year of automatic eligibility rather than two years. In October 2004, it became necessary for children enrolled in MinnesotaCare and Minnesota's Section 1115 waiver programs to reapply for coverage every six months, rather than the previous 12 months. The Department of Human Services estimates that in FY 2007 this change will reduce the average monthly enrollment in MinnesotaCare by 6,000 children.

As families come off of MA, the data does not indicate that they are enrolling in MinnesotaCare as an alternative. Overall, MinnesotaCare is seeing a steady decline in enrollment numbers since July 2003, when most legislative cuts were implemented. There was a 6% decrease in enrollment numbers for children under 21 from August 2003 (70,447) to August 2004 (66,019).

Effective 7/1/2003 changes were made to General Assistance Medical Care (GAMC) and Emergency GAMC was eliminated, leaving 2,200 of Minnesota's poorest young adults with no health insurance or source of regular care. In the second half of 2003, coinciding with these cuts to GAMC, Hennepin County (largest populated county) experienced a 39% increase in uninsured patients requiring inpatient services and an 8% increase in those requiring outpatient services. After July 1, 2003, Hennepin County's Assured Access Program (not insurance, but enables enrollees who are uninsured and ineligible for public programs to receive discounted services from participating community clinics) saw an increase in enrollment for children of 55%.

Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs) are areas that are federally designated as lacking adequate health care services. Populations in 54 out of 87 counties are in federally designated Health Professional Shortage Areas (HPSAs) for primary care. 73 counties include either a HPSA or an MUA designation or both. Additionally, populations in 41 counties are in dental HPSAs and populations in 70 counties are in mental health HPSAs. While some of these designations are in urban areas with high percentages of poverty and minority populations, the majority are located in frontier and rural counties in the state. These areas tend to lack employment opportunities and experience a higher rate of uninsurance than other areas in the state. See the HPSAs maps on the following websites. The first one is rural at http://www.health.state.mn.us/divs/chs/DDHPSADec04.jpg and the urban map is at http://www.health.state.mn.us/divs/chs/MetroDentDec04.jpg. Also the Medically Underserved Areas can be seen at http://www.health.state.mn.us/divs/chs/MUASept04.jpg for rural areas and
http://www.health.state.mn.us/divs/chs/MetroMUAFeb05.jpg for urban area.

HPSAs and MUAs help meet the health care needs of medically underserved rural and urban populations of Minnesota by supporting the health care safety net services. Clinics located in these areas and providing health care services to underserved population can meet eligibility criteria for a number of federal and state assistance programs, including grants and reimbursement incentive programs. ***/2010/ Community Health Centers in Minnesota collectively serve 180,000 patients per year -- 38 percent of them uninsured, 43 percent in public insurance programs and 6 percent on Medicare. One center in the heart of Minneapolis expects to go from serving 8,300 patients in 2001 to 13,000 in 2009 due to the recession. //2010//***

STATE LEVEL INITIATIVES
Minnesota Mental Health Action Group (MMHAG) MMHAG is a public-private effort to improve mental heath services in Minnesota. Launched by the Minnesota Department of Human Services, all of Minnesota's major health plans and facilitated by the Citizen's League -- MMHAG

has begun developing strategies to implement the changes required to bring about a more coordinated system that meets the needs both of adults and those of children. MMHAG created a blueprint for addressing these issues that called for 1) early identification of mental health problems and early, effective intervention; 2) increasing access to services and inpatient psychiatric hospital beds; and development of quality standards monitoring processes, and introduction of evidence based practices into children's mental health care. Based on recommendations from MMHAG, the 2006 Legislature adopted some key components of the Governor's Mental Health Imitative. These included more than $10 million in new funding to address the shortage of psychiatrists, improve front-line services for children and adults; track service availability; and to begin to evaluate outcomes. These changes help set the stage for other elements of the initiative to be proposed in the next legislative session.

/2008/ A key accomplishement of the 2007 legislative session is the net investment of approximately $34 million for the Governor's Mental Health Initiative. The initiative is aimed at improving the accessibility, quality and accountability of publicly funded mental health services. It is based on the recommendations of the Minnesota Mental Health Action Group and builds on mental health improvements approved in 2006. Under this legislation, all publicly funded health care programs will have a comprehensive mental health benefit set. Significant new funding is targeted at shoring up school-based mental health services for uninsured and under-insured children and providing respite care services for families of children with severe emotional disturbance and with expanding mental health crisis intervention as a first-line safety net for children and adults.//2008//

/2009/ In 2008, Governor Pawlenty signed significant health care reform legislation into law. These reforms create a comprehensive health care package making significant advances for Minnesotans. During fiscal years 2010 and 2011, $47 million will be provided to local public health agencies and tribal governments to reduce the percentage of Minnesotans who are overweight and reduce the use of tobacco. The law also: 1). expands MinnesotaCare eligibility for adults without children to 250 percent of FPG, streamlines access to applications for state public health care programs, 2) includes broad reforms to increase access to private coverage through limited tax credits for the uninsured and Section 125 plans for employees to purchase insurance with pre-tax dollars, 3) creates a work group to make recommendations on an essential set of benefits, 4) requires the Departments of Health and Human Services to develop and implement standards of certification for health care homes by July 1, 2009, 5) promotes the use of health care homes to coordinate care for individuals with complex or chronic conditions, 6) implements a payment system for care coordination, 7) requires providers use nationally-certified electronic health record systems, 8) advances the use of health information technology by requiring all pharmacy prescriptions be ordered electronically by 2011 and 9) includes changes that will provide Minnesotans with more tools to compare cost and quality and that set the stage for payment reform. //2009//

/2010/Under a continuing state commitment to improve health care quality and contain costs significant work has occurred over this last year in Minnesota's health care reform activities. The law passed in 2008, sets into place reforms in four broad areas: 1) population health with the goal of investing in public health to help Minnesotans live longer, better, healthier lives by reducing the burden of chronic disease. Applications have been reviewed from Community Health Boards and Tribal Governments for distribution of $47 million in the next two years to address obesity and tobacco as the key risk factors to target interventions. Grantees will utilize policy, systems and environmental changes in four settings: schools, work sites, health care and community; 2) market transparency and enhanced information with the goal of providing public reporting of health care costs and quality information that will allow providers, purchasers, policymakers and consumer to make better decision about health and health care delivery; 3) payment reform with the goal to promote quality outcomes, better management of chronic disease and more efficient resource use; 4) consumer engagement with the goal to empower consumers to be more proactive and

knowledgeable about how health status and health care quality impact health care costs and to encourage primary care providers, families and patients work in partnership to improve health outcomes and quality of life for individuals with chronic health conditions and disabilities. Rules are being promulgated for health care home certification and technical assistance is being provided to interested health care home teams//2010//

BUILD Initiative in Minnesota Minnesota's BUILD Initiative has developed a statewide five-year plan, Minnesota's Road Map for School Readiness, to help ensure that the programs needed by children and families are available, affordable, and of high quality. Infrastructure, as well as programs, is vital. Elements of the BUILD early childhood infrastructure are early learning standards, assessment, professional development, a quality rating system, governance, adequate resources and financing, and evaluation. Priorities for 2006 include 1) mobilize support for school readiness; 2) enhance quality choices for parents; 3) secure funding; and 4) strengthen accountability. //2007// /2008/ Interest for the 2007 legislative session was directed at expanding home visiting funding and services to support school readiness.//2008// ***/2010/ The MN Early Childhood Comprehensive Systems grant leadership team collaborated with the BUILD/Ready 4K staff to complete the early childhood outcomes, indicators, and evidence-based strategies report. This report provided the foundation for the Early Childhood Business Plan developed in coordination with BUILD/Ready 4K, private foundations, the business community and community groups.//2010//***

TITLE V PROGRAM ROLE

The role of the Title V program in the state's health care delivery environment is to assess the health needs of mothers, children, and their families and to use that information to effectively advocate on their behalf in the development of policies concerning organizational and operational issues of health systems, and to advocate for programs and funding streams which have the potential to improve their health. The state's Title V program does have a significant assurance role. The Title V program areas of MCH and CYSHCN administer, coordinate and support many activities addressing maternal and child health, including the Title V Block Grant. The maternal and child health responsibilities of the Division include statewide planning and coordination of services through the acquisition and analysis of population-based data, the provision of technical support and training; coordination of various public and private efforts; and support for targeted preventive health services in communities with significant populations of high risk and low income families.

Program goals described in a later section are accomplished through partnerships with both state and local level agencies. The Department has interagency agreements with the Department of Human Services related to Title V/Title XIX activities, and also partners with local Community Health Boards (local public health entities), the Minnesota Department's of Education, Economic Security, Corrections, and Public Safety. Along with many other institutions of higher education, Minnesota is fortunate to have an excellent School of Public Health at the University Of Minnesota's Twin Cities campus. The close working relationship with this school, particularly with the MCH and nursing programs provides resources for both members of this partnership and future MCH practitioners.

CURRENT DEPARTMENTAL PRIORITIES/INITIATIVES

As the Minnesota Department of Health positions itself for the next years of this decade, legislative and gubernatorial direction as well as community- and population-based health issues will shape its priorities. The current governor, Tim Pawlenty, has identified health prevention as a priority, with a specific emphasis on obesity. The MDH administration, through it's Health Steering Team (HST), made up of the Executive Office staff and Division Directors, has undertaken strategic planning activities which led to the development of work groups to review these priorities: 1. Vision for MDH; 2. Organizational Structure; 3. Regulatory Roles, Responsibilities and Process; 4. Defining a Coordinated Process for Pursuing Funding for MDH Priorities; 5. Interagency Initiatives; 6. Providing Optimal Support to Local Agencies Responsible

for Public Health; and 7. Data Collection.

/2007/ Through the strategic planning process, the Department of Health identified four priority focus areas: Emergency Preparedness; Health Disparities; Preparing for an Aging Population and Health Care System Reform. Committees have been charged with 1) taking a department-wide perspective on the priority; 2) identifying key measures and outcomes the department should accomplish or work toward; 3) identifying how each division contributes to the outcomes and 4) coordinating and monitoring the department's effectiveness in each priority area. The work on these new priorities has just started but they will help frame the work of the Department over the next several years. //2007// /2008/ The Bureau of Community and Family Health Promotion which includes the Division of Community and Family Health as well as the Office of Minority and Multicultural Health and the Health Promotion and Chronic Disease Division has begun a strategic planning process to identify how the Divisions within the Bureau can work together on major public health efforts. Obesity and infant mortality have been identified as two areas for joint efforts. //2008// /2009/ With the Health Care Reform legislation there will be a need for close partnerships within the Bureau, between Bureaus and between state agencies and other key stakeholders. The Bureau of Community and Family Health houses two primary areas in the Health Care Reform legislation, the Statewide Health Improvement Project (SHIP) which is housed in the Health Promotion and Chronic Disease Division and Health Care Home activities which is housed in the Division of Community and Family Health. Additional information on this legislation can be found under STATE LEVEL INITATIVES found earlier in this section. //2009//

Throughout 1998 the Department undertook a comprehensive effort to revise the state's public health goals and objectives and published Strategies for Public Health. This document is a compendium of ideas, experience and research offered to help local public health and other community agencies achieve the objectives of Healthy Minnesotans, 2004. Work is now underway to update this document for a Healthy Minnesotan's 2010. Title V staff will be responsible for the update the the Goals and Strategies impacting maternal and child health populations.

/2010/ In 2009, the Department once again began to move forward on a strategic planning process that would provide a common framework to discuss and prioritize the various pubic health goals that are being addressed within the Department, its divisions and the broader public health system. The initial phase was to align the various public health goals of the Department within a framework of six broad areas. The framework goals are: Promote health communities and eliminate disparities throughout the lifespan; Prevent the occurrence and spread of infectious disease; make physical environments safe and healthy; Prepare for disasters and emergencies; Help all people get affordable, accessible and quality health services and; Assure a strong public health system. //2010//

Initially established in the Community Health Services (CHS) Act of 1976, Minnesota has a strong public health infrastructure system of locally operated public health agencies and a good relationship between the state and local entities. As part of this original CHS Act, the Minnesota Legislature created the State CHS Advisory Committee (SCHSAC) that provides recommendations to the Commissioner of Health. This statute was revised in 1987 to create the Local Public Health Act, and again in 2003 when significant administrative changes were made.

These revisions included changes in funding for local public health wherein eight funding sources were combined in order to achieve administrative efficiencies, better target local priorities, and move towards results-based accountability. These grants are: the Community Health Services Subsidy, Maternal and Child Health (state funding), WIC (state funding), the Infant Mortality Grant, the Family Home Visiting Grant, the Youth Risk Behavior Grant, the MN ENABL grant, and the Eliminating Health Disparities Grant to Tribal governments. The combined funds are distributed through two formulas -- one to city and county-based community health boards and one to Tribal governments.

Additionally, these administrative changes necessitated planning to create accountability measures -- through development of statewide outcomes associated with a list of essential activities, as well as a revised reporting system. Title V staff have been very actively involved in the planning and development of these changes. Through this work six broad areas of public health responsibility were defined: assure an adequate local public health infrastructure; promote healthy communities and healthy behaviors; prevent the spread of infectious disease; protect against environmental health hazards; prepare for and respond to disasters and assist communities in recovery; and assure access and quality in health services. Title V related work is found in all six responsibilities. /2007/ Statewide outcomes identified for each of the six essential public health responsibilities support the work of the Title V programs and strengthen the partnership around maternal and child health issues with local public health agencies. There are 35 statewide outcomes and except for the outcome to "reduce the rate of hospital admissions for falls in persons aged 65 and older" all outcomes would improve overall maternal and child health within the state. //2007//

More information on this significant planning and infrastructure building activity can be found at http://www.health.state.mn.us/phsystem.html#essential A schematic representation on Minnesota's local public health improvement process is available http://www.health.state.mn.us/cfh/na

Decision-making Processes

There are a number of institutionalized forums that allow the Commissioner of Health, and the Community and Family Health Division Director to remain up-to-date on the social, political and economic dynamics affecting health care issues. All of the groups described below provide for a statewide perspective of various stakeholders on different policy issues, which affords the Title V Directors a number of different vehicles for defining problems and policy and for feedback on recently enacted policy.

1. The Health Steering Team (HST) HST consists of the health department's Executive Office staff and the Division Directors. It meets monthly to provide input into departmental policies, determine priorities, and to identify and resolve issues. /2009/ HST now meets twice a month. //2009//

2. The Maternal and Child Health Advisory Task Force (MCHATF) is a statutorily created standing advisory committee that assists the Commissioner of Health on selected policy issues. It is a 15-member group equally represented by consumers, maternal and child health professionals, and community health agency members with ex-officio representation from the Minnesota Department of Human Services; the Minnesota Department of Education; and the University of Minnesota MCH Program. Its purpose is to advise the Commissioner, the Division Director and the Title V program on the health status and health care needs of mothers and children. In 2005 the MCHATF created two priority work groups to focus on: 1) monitoring the impact of the 2003-2004 Legislative Session policy and budget changes, and 2) maintaining and improving early childhood programming. /2007/ Significant time this past year has been spent on developing recommendations for the Commissioner of Health in the areas of child and adolescent health, perinatal health, and children with special health care needs. This work builds on the MCH needs assessment completed in 2005. Each recommendation defines specific strategies or action steps that could be taken to address one or more of the state priorities identified in the needs assessment process. As of June 30, 2006 recommendations have been approved for child and adolescent health and prenatal health. Recommendations for children with special health care needs will be developed during the summer of 2006 and the full report and recommendations will be forwarded to the Commissioner of Health in the fall of 2006. This work will be used in refining the work of the Title V programs over the next year. //2007// /2008/ The Commissioner of Health, after reviewing the report, charged the MCHATF to work in partnership with the Office of Minority and Multicultural Health and their Advisory Committee to develop strategies and next steps to reduce the disparities in infant mortality by 50 percent by the year 2010. During this past legislative session, the sunset date of the MCHATF was extended until

June 30, 2011. //2008//

3. The State Community Health Services Advisory Committee (SCHSAC) is a standing legislatively mandated advisory committee comprised of county commissioners and local community health administrators. It meets at least four times a year and its purpose is to advise the Commissioner of Health on all matters relating to the development, maintenance, funding and evaluation of the local public health system. Each year the SCHSAC forms 3-5 work groups comprised of local public health experts to address topics of pressing interest to local public health agencies. It also sponsors an annual statewide conference for state and local public health professionals.

4. The Rural Health Advisory Committee consists of legislators, rural providers, and consumers. Its purpose is to advise the Commissioner and other state agencies on rural health issues and rural health planning. It too carries out its responsibilities through work groups. Their current focus is on mental health issues in rural communities. /2007/ Focus areas currently are the aging population, E-Health and telemedicine. //2007// /2009/ Earlier this year, the Rural Health Advisory Committee completed a report on Health Care Reform: Addressing the Needs of Rural Minnesotans, and currently is working to develop a new model of rural health care delivery to respond to changing demographics, technology and workforce trends. This project will be addressing the continuum of care and opportunities for integration across the range from prevention and primary care to mental health and aging services. //2009//

5. Title V/Title XIX: The senior program managers for the Title V and the Title XIX programs meet periodically to discuss maternal and child health issues and proposed changes in their respective programs and concerns due to changes in federal and/or state policy. The Title XIX agency is also the designated Title XXI agency.

6. The Management team of the Division of Community and Family Health meets on a monthly basis to resolve immediate operational issues and to discuss and define long-range issues. /2008/ The Management Team of the Division of Community and Family Health is comprised of Division management, (Division Director and Assistant Director), the four Section Managers (MCH, MCSHN, WIC and Office of Public Health Practice), and their respective supervisory staff. The Management Team meets weekly to discuss issues and share information. //2008//

B. Agency Capacity

The mission of the Community and Family Health (CFH) Division is to provide collaborative public health leadership that supports and strengthens systems to ensure that families and communities are healthy. This is done by partnering to: ensure a coordinated state and local public health infrastructure; improve the health of mothers, children and families; promote access to quality health care for vulnerable, underserved and rural populations; and provide financial support, technical assistance, accurate information and coordination to strengthen community-based systems.

The vision for the public health system in Minnesota is of a strong and dynamic partnership of governments, fully equipped to address the changing needs of the public's health. Minnesota Statutes Section 144.05 gives authority to the Commissioner of Health to develop and maintain an organized statewide system of programs and services to protect, maintain and improve the health of Minnesotans. This includes authority to collect data, prevent disease and disability, establish and enforce health standards, train health professionals, coordinate local, state and federal programs, assess and evaluate the effectiveness and efficiency of health service systems and public health programs in the state, and advise the governor and legislature on matters relating to the public's health.

The language within Minnesota Statutes Chapter 145 lays out the state requirements for the

distribution of the Maternal and Child Health block grant, with two thirds to go out to local Community Health Boards through a formula; establishes the MCH Advisory Task Force; and articulates program requirements for use of state funds for WIC, family planning, abstinence education, fetal alcohol syndrome, and home visiting. /2007/ and the Woman's Right to Know and Positive Alternatives Programs. //2007// The Minnesota statute articulates that a third of the block grant money retained by the Commissioner of Health may be used to: 1) meet federal maternal and child block grant requirements of a statewide needs assessment every five years and prepare the annual federal block grant application and report; 2) collect and disseminate statewide data on the health status of mothers and children within one year of the end of the year; (3) provide technical assistance to community health boards in meeting statewide outcomes; (4) evaluate the impact of maternal and child health activities on the health status of mothers and children; (5) provide services to children under age 16 receiving benefits under Title XVI of the Social Security Act; and (6) perform other maternal and child health activities as listed in federal code for the MCH block grant and as deemed necessary by the commissioner.

The delivery of primary and preventive public health services by local government in Minnesota occurs within a framework governed by "Community Health Boards (CHB)." The Boards themselves are comprised of elected officials, either county commissioners or city council members. The Boards provide policy formulation and oversight of the local public health administrative agencies which are responsible for conducting public health core functions. There are 53 CHBs in the state including 27 single-county boards, 59 counties cooperating in 21 multi-county boards, four cities, and one city-county board. This infrastructure provides for a community-based decision-making process based on a needs assessment with state leadership and support. The process recognizes differences among communities and provides a flexible range of responses. Core funding is provided through the Local Public Health Act ($31 million including $6.1 million of Title V funds). Total CHB expenditures for 2005 was $282 million of which a third was from local taxes. /2009/ Total CHB expenditures for local public health activities for calender year 2007 was $302 million, of which a third continued to be from local taxes. //2009//
/2010/ Total expenditures for local public health activities for calendar year 2008 were $317 million, of which one-third continued to be from local taxes. The federal MCH Block Grant was 2 percent of total funds available to local public health.//2010//

CROSS-CUTTING TITLE V PROGRAM CAPACITY
The MCH Advisory Task Force: The Maternal and Child Health (MCH) Advisory Task Force was created by the Minnesota Legislature in 1982 to advise the Commissioner of Health on the health status and health care services needs of Minnesota's mothers and children, and the distribution and use of federal and state funds for MCH services. Fifteen members are appointed by the Commissioner with five each representing MCH professionals, MCH consumers, and Community Health Boards. Terms are four years, half coterminous with the governor's term and half one year later. Work groups of the Task Force are often convened with a specific charge to bring back to the full Task Force recommendations made following more in-depth research and discussion. Current work groups include monitoring theimpact of the 2003-2004 legislative session policy and budget changes on mothers and children, and improving early childhood programming. /2007/ The new work plan for the next year revolves around developing strategies or action steps to address the state priorities identified in the needs assessment process. //2007// /2008/ The Commissioner of Health charged the MCH Advisory Task Force to work with the Office of Minority and Multicultural Health and their advisory task force to recommend strategies and next steps that would allow Minnesota to fully meet the goal of reducing the gap in infant mortality rates by 50 percent by the year 2010. The 2007 Legislature also extended the sunset date of the MCH Advisory Task Force until June 30, 2011. //2008// ***/2010/ Next legislative session, the sunset date for the MCH Advisory Task Force will be proposed to be removed in recognition of the onging benefits of this group to the overall health and well being of the MCH and CSHCN populations.//2010//***

MCH Epidemiology: A newly formed data/epi team was created in response to recommendations

made during the 2003 CAST 5 data capacity process. The purpose of the team is to provide a broad base of technical expertise and support for data-related activities (e.g., needs assessment, research, and program evaluation) to CFH staff with emphasis on building the capacity of staff to work with data through one-on-one coaching, consultation, and division-wide trainings. The team consists of 3 PhD level staff: the SSDI research scientist, another research scientist, and an epidemiologist. This team brings increased methodological and analytic capacity and will leverage efforts to advance SSDI project objectives. The Data/Epi team has been actively partnering with programs on data activities, working on committees, organizing training opportunities, and developing structures for increased collaboration and data sharing within and across programs. Among the new structures formed is a Data Users Group, which is intended to foster communication and collaboration among researchers, analysts, policy planners, and others responsible for data utilization in and outside of the MDH. /2007/ In 2005, Title V and Title XIX entered into an Interagency Agreement whereby Title V agreed to cover the salaries of 1.5 FTE epidemiologists at the Department of Human Services to be able to use Medicaid data to work on jointly identified issues. The first project identified was determining cost effectiveness of a medical home model for children and youth with special health care needs covered by Medicaid/MinnesotaCare. //2007// /2008/ PRAMS was moved organizationally into the Division of Community and Family Health and expands the work of the Data/Epi Unit. The 2007 legislative session also provided additional funding for up to 2.5 FTEs to provide research support to the development of a new data system for Newborn Hearing Screening and Follow-up and to develop a statewide evaluation of the Family Home Visiting Program. //2008// /2009/ The Title V-CYSHCN program is the recipient of a MCH Bureau EHDI Loss to Follow-Up grant. The grant included a 0.5 FTE epidemiologist in the first year. //2009// ***/2010/ Due to the report lead by the MCH Epidemiologist on Autism Spectrum Disorders Among Preschool Children Participating in Minneapolis Public Schools Early Childhood Special Education Programs a focus for the upcoming year will be moving forward on the recommendations made in this report. This will require additional 1.5 staff on a one year temporary basis. //2010//***

MCH Special Projects Grant: The Maternal and Child Health Special Projects (MCHSP) grant program was created in 1985 to distribute two-thirds of Minnesota's share of the federal MCH Title V Block Grant and an appropriation of state general funding to Minnesota's Community Health Boards. MCHSP funds provide core funding for support of local public health infrastructure focused on the improved health of mothers, children, and their families. The program also targets funds to serve high-risk and low-income individuals in statewide priority service areas: improved pregnancy outcomes, family planning, children with handicapping conditions/chronic illness, and child and adolescent health. The 2003 Legislature consolidated MCH dollars, along with seven other categorical programs, into the resulting Local Public Health Grant (LPHG) that provides funding for Community Health Boards and Tribal Governments. Accountability for MCH block grant dollars remains separate within this LPHG structure. At the same time the Community Health Board match for the federal MCH Block Grant funds was raised from 25 percent to 50 percent.

Tribal Governments: While the Department of Health and the Community and Family Health Division have been working with tribal governments for some time, the process became more formalized in 2003 with the establishment and the hiring of a Tribal Liaison. Located within the Office of Minority and Multi-Cultural Health (OMMH), the position is uniquely situated to establish stronger ties with Tribal Governments and Tribal Health Directors. Legislative action in 2003 acknowledged the role Tribal Governments play in the health status of their communities by including them in the Local Public Health Grant. In response to the significant disparities in infant mortality, childhood obesity, teen suicides and teen pregnancies, tribes were directed to use the new money in this grant for maternal and child issues. Staff work closely with the Tribal Health Liaison to provide technical assistance and support to the Tribal health staff and programs for all three MCH population groups. /2008/ Currently infant mortality staff are working closely with Tribal Governments on infant death reviews to determine what strategies might be effective in reducing the number of American Indian infant deaths. //2008//
/2009/ Staff completed the Native American Infant Morbidity Review report. Report findings will

be used to guide next steps in efforts to reduce the continued disparities seen in Native American infant deaths compared to white infant deaths. //2009//

Dental Health Program: /2009/ Minnesota has been able to achieve water fluoridation for 98.8% of our population significantly impacting the overall oral health of our residents.//2009// The dental health program provides oral health promotion training, technical consultation and assistance to professionals, and educational materials to CHBs, schools and the general public. Program staff partners with the Department of Human Services in areas of dental policy and access issues. With funding from HRSA, Minnesota Children's Oral Healthcare Access Project grant promoted the oral health of pregnant women and young children, to improve the early oral health status of infants and children served by Minnesota WIC program, and improve the awareness and anticipatory guidance skills of WIC parents related to the oral health needs of their children. /2008/ In partnership with the Minnesota Department of Human Services and the Minnesota Dental Association, the Department of Health will be inviting interested stakeholders to participate in an advisory committee to develop a Public Health/Oral Health Stateplan. The first meeting of this group is targeted for October. The Association of State and Territory Dental Directors will be providing technical assistance to this effort and the Division of Community and Family Health will be responsible for overseeing the process. //2008// /2009/ The Oral Health State Summit is scheduled to be held on November 7, 2008. This event will be used to begin the development of a Minnesota specific oral health state plan. In an effort to establish adequate funding for statewide oral health improvement efforts staff have submitted a CDC Oral Health Infrastructure Grant and a grant to HRSA to establish an oral health surveillance system. //2009// ***/2010/ The Department recieved both the CDC Infrastructure Grant and the HRSA grant. Because of the broader chronic disease focus, the Oral Health Program was transferred to the Division of Health Promotion and Chronic Disease. However, oral health issues remain a high priority for the MCH programs and they will continue their collaboration with the Oral Health Program.//2010//***

In addition to specific program areas listed below, Title V staff and programs work to leverage capacity by partnering with related programs situated in other Divisions within MDH. These include lead screening and abatement, Birth Defects Information System, immunizations, STI and HIV programs, breast and cervical cancer control, asthma, several health promotion program areas, the methamphetamine program, and children's environmental health.

POPULATION CAPACITY: PREGNANT WOMEN, MOTHERS AND INFANTS
Perinatal - The perinatal focus of work involves program staff with health providers to develop quality preconception, family planning, prenatal, perinatal, and genetics services that increase the potential for healthy pregnancies and newborns. Staff assess needs, develop standards, and provide technical support services, training, and public education. This component assures counseling and education for patients and family members with known or suspected genetic diseases; assures genetic consultation, education and diagnostic support to physicians and other health professionals; and partners with the Public Health Laboratories program for detection of metabolic diseases through newborn screening. The infant mortality staff provides education, information and assistance to community and Tribal public health, works closely with Twin Cities Healthy Start, and with the OMMH in their Eliminating Health Disparities Initiative (EHDI) in the area of infant mortality reduction. Infant mortality staff are active with the Prematurity Campaign of the March of Dimes and with the Minnesota Perinatal Organization and work with the Minnesota SIDS Center. In response to the increase of infant deaths due to bedsharing, Infant Sleep Safety Education folders and a brochure entitled "Safety Tips for Bedsharing with Your Baby" were made available. This brochure is distributed to birthing hospitals throughout the state. Another compiled education folder brings together all the infant sleep safety messages including information on bedsharing, and are being distributed to local public health, tribal health, and community-based organization. /2007/ The 2005 Legislative session passed language that required the Department of Health to develop and distribute information on postpartum depression and Shaken Baby Syndrome prevention. Working with community partners, MDH identified materials that are to be used by hospitals and healthcare providers to educate women

and their families regarding postpartum depression. Guidance was developed for health care providers regarding educating parents during well-child checks for children birth to 3 years of age regarding Shaken Baby Syndrome prevention. //2007// /2008/ A preconception conference titled "A Lifespan Approach to Reproductive Health: Getting it Right" is being co-sponsored this fall with the March of Dimes and the University of Minnesota. //2008// /2009/ The conference brought together approximately 150 people. Plans are currently underway for a second conference this fall.//2009// ***/2010/ The second annual preconception conference focused on reaching underserved populations. The conference was attended by 138 persons from across the state and had several breakout sessions on culturally specific strategies to reach women of color, immigrants, and American Indians with education and interventions designed to assure all women are healthy throughout their reproductive years and plan and are ready for pregnancy The third preconception care conference is planned for October 2009.//2010//***

Substance Abuse - These activities focus on the childbearing and prenatal population and include dissemination of a Women and Substance Use in the Childbearing Years Prevention Primer, a compendium of resources and a guide for client and community prevention educators and planners. Work is underway on the CDC FAS Prevention grant with the purpose to increase Minnesota's capacity to integrate targeted and population based alcohol and contraception screening and behavior change interventions for women of childbearing age in select community settings; to reduce binge and prenatal drinking in women 18-44; to increase contraception use in women 18-44; to increase collection and use of data on women's drinking and contraceptive use; and to prevent and reduce FAS in targeted prenatal and preconceptional populations at risk for binge and prenatal drinking. MDH oversees a state funded FAS prevention grant to a local advocacy organization for work on public education, screening and evaluation activities, and intervention programs. /2008/ The 2007 Legislature authorized an additional $500,000 a year in state general funds, bringing the total available a year to $1,690,000 for FAS prevention and intervention. //2008// Prenatal smoking prevention and cessation activities include work with the Indigenous People's Task Force, and work with a new state partnership sponsored and facilitated through the AMCHP, ACOG, PPA, and CDC technical assistance project.

Reproductive Health - The Family Planning Special Projects grants provide funding and technical assistance and support to the 41 community-based clinics and organizations that provide assessment, education and contraceptive methods services, and supports a family planning and STI hotline. Staff work with policy issues at the legislature and with implementation activities of the new state 1115 family planning waiver demonstration project. Abstinence grant activities include: community organization activities, use of a curriculum consistent with established principles for education, a media campaign, and state directed training and technical assistance for community-based projects. /2008/ The state's 1115 family planning waiver began to provide services as of July 1, 2006. The 2007 Legislative session restored the 2003 family planning reductions of $1,156,000 a year but at the same time reduced funding for Minnesota's abstinence program by $220,000 a year. //2008//
/2009/ Funding for the abstinence grant program (MN ENABL) was eliminated during the 2008 legislative session. //2009// ***/2010/ Family Planning Special Projects grants were awarded to 32 organizations for 2009-2011. //2010//***

Home visiting - Staff provide support to local public and Tribal health staff for home visiting activities they undertake through the Local Public Health Grant. The state supports NCAST training for home visiting nurses and has increased a focus on maternal and infant mental health training and assessment. Staff provide training to utilize the home safety checklist for injury prevention. /2008/ This program received significant support during the 2007 Legislative session, with an additional $4,000,000 a year added to the existing program's $3,557,000 budget. Legislative language focus home visiting services prenatally whenever possible. Both the Department of Health's role in training and technical assistance as well as its evaluative role were strengthened and funding was directed specifically to these areas. //2008// /2009/ A steering committee and two workgroups - one on training and technical assistance and one on evaluation

- were convened this year. Local health departments have completed and submitted detailed home visiting plans to MDH. //2009// ***/2010/ The department received a $2.5 million grant from the Administration for Children and Youth for evidence-based home visiting programs to prevent child abuse. The new funding will be used to start and train new Nurse-Family Partnership programs in MN. //2010//***

Women's Health - Women's Health Grant activities were focused on increasing the number of low-income women of color receiving primary and preventive health care services by identifying service gaps and eliminating barriers to care. Although this federal grant has now ended, the relationships developed through this grant continue to provide opportunities for collaboration. The Women's Health Team, convened by Title V staff, provides opportunity for women's health programs from across the Department to work together so that systems of care serving women are improved. Working closely with the Community Center of Excellence at Northpoint Clinic, and with the U of M Academic Center of Excellence in women's health, a joint women's health website has been developed at www.healthymnwomen.org. /2009/ MDH has created a Woman's Health Consultant position in the Maternal and Child Health Section. However, due to state budget shortfalls, this position is currently on hold. //2009// ***/2010/ A white paper is currently being prepared to describe programs within the department and assess the needs to address women's health disparities in MN. //2010//***

/2007/ The Positive Alternatives Grant Program: This program funds private, non-profit organizations to support, encourage, and assist women in carrying their pregnancies to term and carrying for their babies after birth. This legislation makes available $2.5 million annually for alternatives-to-abortion programs. Currently 37 organizations have been awarded funding to provide a variety of services to pregnant women including dula and case management services; client advocate services; parenting programs; transitional housing; medical and educational support and necessary items such as cribs, car seats and formula. //2007// /2009/ The Positive Alternatives grant program distributed second round of grants. Thirty-one organizations were awarded funding for the next four year grant cycle. //2009// ***/2010/ An evaluation of the grant program is underway and will provide a description of services, effectiveness and client satisfaction.//2010//***

Infant Health - Staff partner with the MDH Newborn Screening Advisory Committee and with the MDH laboratory on systems development, data and tracking linkages, and providing education, outreach, technical assistance, and materials development. Newborn screening follow-up staff facilitate enhanced care coordination and services for infants found by newborn bloodspot screening. The MDH supports hospitals to provide newborn hearing screening and tracks results through integration with the state's Newborn Bloodspot Screening database, and is developing integration with vital statistics via a web-based system. Staff provide: technical assistance to hospitals; early intervention and follow-up; provider training; public information; and enhancement of a statewide family-to-family support network. Program activities are coordinated with Part C along with other MDH staff, faculty for the University of Minnesota Department of Otolaryngology, and members of the Universal Newborn Hearing Screening Advisory Committee. Staff work with the Departments of Human Services and Education to provide state leadership in early hearing detection and intervention, including tracking and reporting of outcomes. Sixteen regional teams continue to build capacity in their regions to better serve deaf-hard of hearing children and their families. /2008/ The 2007 legislative session mandated newborn hearing screening and requires the Department of Health to establish a Newborn Hearing Screening Advisory Committee to assist in developing the mandated program. The Division of Community and Family Health and the Laboratory Division will be partnering in implementing this new program. //2008// ***/2010/ The 2009 Legislature provided additional funding to provide support and assistance to families with children who are deaf or have a hearing loss. The family support must include direct parent-to-parent assistance and information on communication, educational and medical options.//2010//***

POPULATION CAPACITY: CHILDREN AND ADOLESCENTS

Child and Adolescent Health Screening - This area of work supports accessible quality health and developmental screening and health promotion for all children. Goals of the program are adoption of healthy behaviors and assurance of early identification, treatment and remediation for those with health problems. Services include development of child health screening and health promotion guidelines, provision of training and technical consultation, and public education efforts. Specific programs supported include Child and Teen Checkups (Minnesota's EPSDT program) consultation, Nursing Child Assessment Satellite Training (NCAST) program, the scoliosis screening program, and maternal/infant mental health. /2009/Both Title V programs have joined with the state Title XIX program and the state chapter of the American Academy of Pediatrics to form the Minnesota Child Health Improvement Project (MN-CHIP). Modeled after the successful Vermont "V-CHIP" program, the mission of this public/private partnership is to assure optimal child healthcare by creating and supporting continuous quality improvement in clinical practices.//2009// ***/2010/ Title V staff serve on the MnCHIP advisory group and will continue to provide technical assistance and consultation to C&TC primary care providers as needed on future improvement projects. The Parentsknow website was developed in collaboration with the Minnesota Department of Education to provide easy access to information on child development.//2010//***

School Health / Child Care - Specific attention is given to promotion of the health and safety of children in child care settings, school health (including hearing and vision screening), adolescent health, and children's mental health issues. Staff work closely with the Title V-CYSHCN as well as staff from related state agencies such as Departments of Education and Human Services. A report has been produced on a comprehensive system for the safe administration of medications in Minnesota schools, anchored by the development of statewide standards and guidelines and local district policies and procedures. This is available at http://www.health.state.mn.us/divs/fh/mch/schoolhealth.medadmin/. /2007/ These guidelines are being implemented in schools throughout the state through trainings and technical assistance. //2007// ***/2010/ The school nurse consultant worked with infectious disease staff to develop guidelines for H1N1 at summer camps. Additional guidelines are being developed for schools.//2010//***

Adolescent Health - Adolescent preventive health services are addressed through outreach and implementation of "Being, Belonging, Becoming: MN Adolescent Health Action Plan", which includes a focus on strengthening adolescent health care services and systems. Outreach includes technical assistance on use of a youth development framework for addressing adolescent health issues, information about best practices and health care guidelines, implementation of recommendations for action, and use of available resources to support effective strategies. Staff provides technical assistance to EHDI grantees, local public health and other community-based entities, and works closely with the Department of Education, other adolescent program areas within MDH, and the University of Minnesota Konopka Institute for Best Practice in Adolescent Health, Division of General Pediatrics and Adolescent Health, building skill and capacity of adolescent-focused work and programs across the state. /2008/ The adolescent health coordinator is currently in the process of implementing the Adolescent Health System Capacity Tool developed by Association of Maternal and Child Health Programs and the State Adolescent Health Coordinators Network (SAHCN). The goals of the project are: 1.) document existing capacity of MDH to support adolescent health; 2.) establish if, and how, MDH is meeting the needs of our local public health agencies related to adolescent health; 3.) further define the roles of the Department of Health in addressing adolescent health; and 4.) improve the quality, and coordination, of MDH activities related to adolescent health. //2008// /2009/ Work on the Adolescent Health System Capacity tool will continue this fall. The Title V-CYSHCN program co-sponsored "Building an Interdisciplinary Research Agenda to Enhance Quality of Life and Transition to Adulthood for Youth with Chronic Conditions" with the Center for Children with Special Health Care Needs at the University of Minnesota's School of Nursing in the spring of 2008. In addition, the Title V program partnered with the adult mental health services division of the state's department of human services to fund suicide prevention grants using state general

funds and SAMHSA block grant funds. Target populations included adolescents, especially those with special health need; adults 18-35 and adults 55 and over. //2009// ***/2010/The adolescent health coordinator received a grant through AMCHP and NACCHO for Teen Pregnancy and STD/HIV Prevention to work collaboratively with the Department of Education, a local health department, the local teen pregnancy prevention coalition, and MOAPPP, to address high rates of STDs and teen pregnancies in rural MN.//2010//***

Early Childhood - The MCH Bureau's State Early Childhood Comprehensive Systems Planning Grant is underway to develop a state plan for an integrated comprehensive early childhood screening system. The interagency partnerships between Title V, the Departments of Human Services and Education, and Minnesota Head Start have increased efforts to decrease duplication of preventive care and foster coordination between childhood programs that require preventive visits. Work through these relationships has provided joint regional screening workshops and the development of the Minnesota Child Health and Development Screening Quality Indicators: A Comprehensive Framework to Build and Evaluate Community Based Screening Systems. ***./2010/ MN recently received the ECCS grant for the next 3 years. Key goals include to: 1) Create a statewide vision and governance structure; 2) Provide a coordinated and comprehensive EC system that addresses the health and well-being of young children and their families; 3) Ensure that children have access to early care and education opportunities; and 4) Ensure that families are supported through programs and services that strengthen parental resilience, social connections, knowledge of parenting and child development, children's social emotional development, economic support and cultural influences.//2010//***

POPULATION CAPACITY: CHILDREN WITH SPECIAL HEALTH NEEDS
Diagnostic Clinics are a component of the MCSHN program and provide quality medical and rehabilitation assessments for children with suspected or diagnosed special health needs, are staffed by a multi-disciplinary team or specialist with pediatric expertise, complement local health care, and are located in communities where such services are not available. Several of these clinics are contracted with institutional providers, including the International Diabetes Center and Gillette Specialty Health Care. /2007/ One clinic is the Development and Behavior Clinic (DBC). The Children's Mental Health Services Division of the Department of Human Services has agreed to assist the Title V - CYSHCN program in analyzing the role of the DBCs as part of the overall children's mental health system. //2007//. ***/2010/ The contract with Gillette Children's Hospital was expanded to include augmentation communication and a grant agreement was entered into with CentraCare of St. Cloud to organize facial-dental clinics in St. Cloud region.//2010//***

Community Systems and Development Team - This team has staff located in District Offices of the state, provides a wide variety of activities at the local, regional, and state levels with public and private agencies and families, including information and referral, child find and outreach, education and training, advocacy, technical consultation, newborn metabolic screening follow-up, and program/policy development. /2007/ The capacity of the team was significantly increased by the addition of another district staff consultant. //2007//

Interagency Systems Development - In addition to the Part C interagency activities, staff participates in the state mandated Minnesota System of Interagency Coordination to support the development and implementation of a coordinated, multidisciplinary, interagency intervention services system for children ages birth through 21 with disabilities. This model, based on Part C, requires the development of an Individual Interagency Intervention Plan for all qualifying children, youth and young adults. Significant interagency planning and negotiating has been required between the Departments of Health, Human Services, Education, and Economic Security to support this multi-agency activity. /2007/ The concepts inherent in collaborative learning sessions that were learned from the medical home collaborative experience will be applied in order to remove barriers to implementation. //2007// ***/2010/ The interagency effort began a focus on transition of 18-21 year olds and will concentrate on that age group in the coming***

year.//2010//

Follow-Along Program - Staff provide technical assistance and training to local public health agencies to support the Follow-Along Program in order to provide periodic monitoring and assessment of infants and toddlers at risk for health and developmental problems and to ensure early identification, assistance and services. The software program for this activity, which uses the Ages and Stages Questionnaire as the screening tool, includes a social emotional component - the ASQ-SE. Special trainings have been targeted on this tool to the Somali population and to the Department of Human Services and local social services agencies on the use of the ASQ-SE to meet the requirements for mental health screening of children in the child welfare system. /2007/ The ASQ and ASQ-SE continues to be adopted by local agencies. It is the screening tool of choice for the Children's Mental Health Services' ABCD-II grant initiative and has been added to the Child and Teen Checkup (EPSDT) program's trainings. //2007//

Research and Policy Analysis - The Research/Analysis and Policy work supports the development and enhancement of capacity to collect and analyze data for research and policy issues around children with special health needs and their families. It has engaged in a number of interagency collaborative activities to assess, direct and influence policy decisions that positively impact children with special health needs. /2007/ Factsheets on each of the 44 conditions followed by the birth defects information system were developed. Leadership will also be provided at the Part C ICC level for what will be a significant expansion of Part C enrollment. //2007//
/2010/ This unit and the MCH epidemiologist provided staff leadership on several internal and external initiatives on autism, including a report on the administrative prevalence of Somali children in Minneapolis special education programs and a one day community forum for Somali parents, health providers and educators.//2010//

Medical Home - Minnesota has adopted the medical home learning model promoted by the National Initiative for Children's Health Care Quality in its national medical home collaborative to advance the medical home concept -- particularly for children with special health needs. Eleven teams are in place throughout the state, each consisting of a pediatrician, a care coordinator, and two parents. Staff working closely with the state chapter of the AAP, has generated responsiveness to some some productive media education and outreach, and will continue this work through the newly awarded New Freedom initiative grant. /2007/ Minnesota participated in the second National Medical Home Learning Collaborative conducted by NICHQ. It was also one of the original 12 grantees under the President's New Freedom Initiative and will continue medical home activities as part of that initiative. //2007// /2008/ The 2007 Legislature allocated $1,000,000 in one time funding to expand the work currently being done on the Medical Home project. The CYSHCN program is currently working with the Department of Human Services and the Minnesota AAP chapter to determine next steps. //2008// /2009/ The 2008 Legislature enacted significant health care reform legislation including legislation establishing the certification of health care homes. Initially, the target population for health care homes is the fee-for-service Medicaid enrollee. However, the legislation envisions all payers and all populations will participate in health care homes. The Title V-CYSHCN program will be involved in the development, implementation and certification of practices/practitioners as health care homes by July of 2009. //2009//***/2010/ The department hired a manager for the health care home unit and this unit spent most of SFY 2009 in developing rules for voluntary certification of practices as health care homes. It is anticipated that these rules will be formally adopted in August of 2009//2010//***

Outreach / education / follow-up - Staff work with Birth Defects Information System (BDIS) staff to provide follow-up to families of all children confirmed as having neural tube defects, cleft-lip/palate or chromosomal anomalies. Staff provide health information related to the infant's condition, and refer the family to additional programs and services and is gearing up to provide these same services for the 44 conditions that BDIS will be tracking.

Staff provides frequent trainings to families and providers about various public program services and how to access them through their "Taking the Maze Out of Funding" sessions. These trainings provide updated information to numerous sectors and providers throughout the state regarding program and policy changes. The Information and Assistance line provides information about and assistance in finding and accessing services and supports for children with special health needs and their families. Additionally, the web-based Central Directory of Early Childhood Services provides information about services and programs in both the web and hard copy format.

Broad dissemination occur of condition-specific Guidelines of Care for Children with Special Health Care Needs which include Asthma, Cerebral Palsy, Cleft Lip and Palate, Feeding Young Children with Cleft Lip and Palate, Congenital Heart Disease, Cystic Fibrosis, Diabetes, Down Syndrome, Deaf and Hard of Hearing, Fetal Alcohol Syndrome and Fetal Alcohol Effect, Hemophilia, Juvenile Rheumatoid Arthritis, Muscular Dystrophy, Neurofibromatosis, PKU, Seizure Disorder, Sickle Cell Disease, and Spina Bifida.

SPECIAL SUPPLEMENTAL NUTRITION PROGRAM (SNP) /WOMEN, INFANT AND CHILDREN (WIC)
Also within the CFH Division, Title V staff work with SNP and WIC staff on many shared goals for healthy pregnant women and improved pregnancy outcomes, and healthy infants and young children. Clearly aligned with Title V program activities, Special Supplemental Nutrition Programs has a total of 30.8 FTEs funded by the U.S. Department of Agriculture. This section is comprised of the Special Supplemental Nutrition Porgram for Women, Infants and Children (WIC) and the Commodity Supplemental Food Program (CFSP). These two programs are designed to improve the health and nutritional status of the eligible populations through the provision of healthy foods, nutrition education and health care referrals. This section distributes federal funds from the United States Department of Agriculture to local Community Health Boards, Community Action Programs, and Tribal governments to administer the WIC program; and to local food banks to administer the CFSP program. Participation rates have been rising steadily and currently, over 123,000 persons per month are served. /2007/ Over 129,600 persons were served in May of 2006. //2007// /2008 Over 135,000 women and children were served in May 2007 in WIC. //2008// /2009/ Currently serving 141,864 participants in May of 2009. //2009//

C. Organizational Structure

The Minnesota Department of Health (MDH) is one of the major administrative agencies of state government. The Commissioner of Health is appointed by the governor with confirmation by the state senate, and serves at the pleasure of the governor. State law imposes upon the Commissioner the broad responsibility for the development and maintenance of an organized system of programs and services for protecting, maintaining, and improving the health of the citizens of Minnesota. ***/2010/ The statutory mission of the MDH is to protect, maintain, and improve the heatlh of all Minnesotans. MDH approaches its work through core agency values of integrity, collaboration, respect, science-based decision making and accountability.//2010//***

The Executive Office is organized into four Bureaus: Policy Quality and Compliance, Health Protection, Community and Family Health Promotion and Administrative Bureau. Within the Bureau of Community and Family Health Promotion is the Division of Community and Family Health, (CFH), which is responsible for the administration of programs carried out by allotments under Title V.

The CFH Division is organized into the Director's Office and six sections: Office of Public Health Practice (OPHP), Office of Rural Health and Primary Care, Supplemental Nutrition Program (WIC), Maternal and Child Health Section (MCH), Minnesota Children with Special Health Needs Section (MCSHN), and Integrated Support for Cross Divisional Activities Section. The last three

sections house the staff and resources where the primary Title V activities take place, although Title V staff work across the whole CFH Division -- as well as across the department. This new Division structure was created in August of 2004, when the Division of Family Health was combined with the Community Health Division. The former Director of the Division of Family Health at that time took on a new role of the Title V Coordinator, under which she reports directly to the Director of the Community and Family Health Division. /2008/ CFH was reorganized into four sections, with the Office of Rural Health and Primary Care moving to the Division of Health Policy and the Integrated Support for Cross Divisional Activities Section eliminated and staff reassigned to other areas within the Division. //2008// ***/2010/ A new section was added this year to oversee the broad activities of Health Care Home implementation.//2010//***

The CFH Director's Office houses 17 staff, 8 of which are at least partially funded by the federal Title V funds: 4 grant and administrative staff, an IT staff, and 3 Data/Epi staff. /2009/ The Director's Office provides overall management of the sections and houses staff who provide shared services to the Division. This includes the Epi and Data Unit, the Communications Unit and grant and financial staff. //2009//

The mission of the MCH Section is to provide statewide leadership and public health information essential for promoting, improving or maintaining the health and well-being of women, children and families throughout Minnesota. The structure to support this work consists of 3 work units: Newborn and Child Health Unit, Family and Women's Health Unit, and the Support Unit. This Section has 7.4 FTEs funded by federal Title V funds; 10.8 FTEs funded by targeted state funds; approximately 14.05 FTEs funded by various federal grant programs; and other positions funded through a mix of sources for a current total of 32.3 FTEs. /2008/Changes during this past year include the addition within the section of the Adolescent and School Health Coordinators (both funded by federal Title V funds), the state funded Positive Alternatives Program, and the transfer of 5 state funded FTE's working on Newborn Screening and Follow-up to the MCSHN Section. //2008// ***/2010/ Reorganization of the MCH Section includes moving the school and adolescent health coordinator positions to the newly named Child and Adolescent Health Unit. The Family and Women's Health Unit has expanded to add a social worker for the home visiting grant. The Support Unit was eliminated and and reduced by 2 positions. Current staff total 26 FTE plus 5 student worker positions.//2010//***

The Minnesota Children with Special Health Needs (MCSHN) Section is the Title V CYSHCN program. As such, it seeks to improve the quality of life for children with special health needs and their families through the promotion of the optimal health, well being, respect and dignity of children and youth with special health needs and their families. MCSHN provides statewide support to achieve: early identification, diagnosis and treatment, family centered services and systems of care, access to health care and related services, community outreach and networking, and collection and dissemination of information and data. MCSHN is structured into the Research and Policy Unit, and the Community and Systems Development Unit, which has 6 staff housed in District Offices across Minnesota. MCSHN has 18.35 FTEs funded by the federal Title V funds, 3.55 FTEs funded through interagency agreements with the Department of Education, 1 FTEs funded by federal grants, and approximately 1.5 state funded FTEs for a total of 24.05 FTEs. /2008/ Five additional state funded positions supporting the Newborn Screening and Follow-up Unit were transferred to MCSHN from MCH. Additional funding received in the 2007 Legislative session with increase that number by 3 FTEs. The Suicide Prevention Program (state funded)was also transferred into the MCSHN program this year to support children's mental health efforts. //2008// /2009/ Significant expansion will be seen in 2008 as up to 12.5 FTEs are expected to be added to implement the health care home activities passed in the 2008 legislative session. //2009// ***/2010/ Health Care Homes became a new Section within the Division of Community and Family Health this year. MCSHN continues to collaborate closely with the new section.//2010//***

The Integrated Support for Cross Divisional Activities Section is responsible for supporting and strengthening cross-divisional activities which include: broad internal and external

communication; how the Division uses data to monitor and evaluate programs and the health status of mothers and children, including children with special health care needs; and work on emerging issues that require Division --wide input and monitoring as well as a special focus on adolescent and school health. This Section has 6.80 FTEs funded by federal Title V funds; 0.4 funded by Preventive Block Grant; 1.5 FTE funded by SSDI; 0.5 FTE funded by CDC funds; and other partial FTEs funded by a mix of state and federal funds, for a total of 9.8 FTEs. /2008/ The Integrated Support for Cross Divisional Activities Section was eliminated and staff reassigned to others areas within the Division. //2008//

As required, organizational charts are available on file in the Director's Office in the Community and Family Health Division.

Local Public Health More detail regarding the structure, function, and Title V relationships with local public health are described in Section B, Agency Capacity. In 2004, the State Community Health Services Advisory Committee appointed a work group to identify essential local public health activities that should be available in all parts of the state. This Essential Local Public Health Activities Framework is intended to: define a set of local public health activities that Minnesotans can count on no matter where in the state they live; recommend a statewide plan for implementation; provide a consistent framework for describing local public health to state and local policy makers and the public; and provide a basis for ongoing measurement, accountability and quality improvement related to the implementation or assurance of essential local activities. The website address http://www.health.state.mn.us/cfh/na provides a schematic of Minnesota's Local Public Health Improvement Process. Title V staff have been and remain actively involved in the ongoing planning for these significant revisions to Minnesota's public health system involving the creation of a set of Essential Local Public Health Activities, Statewide Outcomes, and an Outcome Reporting System. This has provided a good opportunity to insure that MCH related program areas were incorporated into this framework of essential services, statewide outcomes, and development of the reporting system. Title V staff continue a high level of involvement in the ongoing planning, and the training and guidance to local public health as these significant system changes are implemented. More information on this activity is available at http://www.health.state.mn.us/phsystem.html#essential. /2008/ Title V programs continue to participate on this project.//2008//

An attachment is included in this section.

D. Other MCH Capacity

See previous Section C Organizational Structure for the location and numbers of Title V staff.

SENIOR MANAGEMENT BIOGRAPHICAL SKETCHES
The Director of the Community and Family Health Division, has served in that capacity since August of 2004. Prior to that time she was the Director of the Community Health Division for 4 years, and has held a number of positions throughout the Health Department including Tobacco Endowment Director, Manager of Environmental Health Services and Manager of Acute Disease Prevention Services. She has worked at the Department for over 20 years, prior to which she worked in local public health agencies in two different Minnesota counties. She has a Masters in Public Health Nursing from the University of Minnesota, and served a term as president of the Minnesota Public Health Association.

/2007/ The Director of the Community and Family Health Division resigned in June 2006 to take another job. The current interim Division Director has worked for the Department of Health for the last 33 years. For the past ten years, she has served as Assistant Division Director first with the Division of Family Health and then with the Division of Community and Family Health. Her educational background is in nursing and she spent her first 20 years with the department in the area of children with special health care needs. The Department intends to do a national search

for candidates for this position. It is expected that the position will be filled prior to the end of 2006. //2007//

/2008/ The new Director of the Division of Community and Family Health began her job in February 2007 and has extensive experience working in public health, both in service provision and in managing public health programs. She is a registered nurse and has as BA in Human Services Administration from Metropolitan State University in St. Paul, and an MPH from Johns Hopkins University Bloomberg School of Public Health in Baltimore, Maryland. She has clinical nursing experience both at the University of Minnesota and Johns Hopkins hospitals, and served as a nursing advisor in the Cambodian refugee camps along the Thai-Cambodian border. As a Senior Public Health nurse in Arlington County, Virginia, she managed public health support to the county's homeless population, and in 1998, she became the Director of the Office of Population, Health, and Nutrition (PHN) for the United States Agency for International Development in Nairobi, Kenya, having previously managed a regional project operating in east, central, and southern Africa. More recently, she has been serving as Vice President, Program Support Department of Family Health International in Arlington, Virginia where she had oversight of international HIV/AIDS prevention, treatment, care and support programs in over 50 countries. //2008//

The state CYSHCN Director is the MCSHN Section Manager and has a Master's degree in hospital and health care administration and has 21 years of experience in health planning, five in hospital corporation activities, 9 in maternal and child health and 7 in CSHCN.

The state MCH Director is the MCH Section Manager and has worked in public health for 25 years in MCH. Much of her experience has focused on providing services to high risk parents including pregnant and parenting teens. After 20 years of providing MCH services at the local level she accepted a position at the Minnesota Department of Health working in the Reproductive Health Unit. Work in this unit included provision of technical assistance for a MCH programs including MN ENABL (Education Now and Babies Later), TANF home visiting, family planning, infant mortality reduction and women's health. In February 2004 she accepted the position of Maternal Child Health Section Manager at the Minnesota Department of Health. /2008/ The current MCH Section Manager will be leaving in August 2007 to take a new job. Active recruitment for a new Section Manager is all ready underway. //2008// /2009/ Laurel Briske assumed the responsibilities as the manager of this section in August of 2007. Laurel has been at the Minnesota Department of Health nearly 19 years where she served most recently as the public health nursing director in the Office of Public Health Practice. There she managed a technical support and training program for public health nurses and local public health departments. She has also worked in the area of injury and violence prevention, children with special health needs, and child health screening. Laurel has a master's degree in nursing and is a pediatric nurse practitioner with 30 years of experience in public health programs. Prior to coming to the state health department, Laurel worked as a Head Start health consultant for the U.S. Public Health Service, in a primary care clinic for homeless women and children, as a public health nurse in county public health departments and as a school nurse. //2009//

The Title V Coordinator was previously the state MCH Director for 5 years, and has over 20 years of MCH experience -- both at the state and local level. She is an occupational therapist by training and has a MPH in the MCH area from the University of Minnesota. /2008/ This position now is focused on taking the lead role for Child Health Information System development and has assumed a supervisory role for the Data/Epi Unit. //2008//

Parent roles The CYSHCN program has, since FY 2000, had a Family Consultant Advisory Group. Consisting of up to eight parents, this group has brought to policy discussions the voice of parents and their children. Parents demonstrated significant leadership and advocacy skills in service system or policy development at the state or local level prior to his/her selection, and most had been through previous advocacy and or leadership programs. Many parents were either graduates of Parents in Policymaking (a program of the Governor's Council on

Developmental Disabilities) or the Minnesota Early Learning Design {MELD} Special Parent trainings. The Family Voices representative in Minnesota has provided administrative oversight to the Advisory Group.

The Advisory Group has been meeting to review the six core outcomes of the Bureau's ten-year action plan and is framing specific actions for the state's work plan, and has also focused on health disparities documented through analysis of the Minnesota Student Survey. Discussions have also been underway regarding important transition issues of responsibilities of local public health agencies brought about by the 2003 legislative changes in the funding of local public health due to significant budget deficits.

/2008/ A parent summit was held this past year. The targeted audience were parents who sat on work groups, advisory committees, and task forces of the Minnesota Departments of Education, Human Services, and Health. The primary purpose of the summit was to foster leadership skills. The keynote speaker was Eileen Forlenza, Family Consultant with the Colorado Title V program. Plans are currently underway to form a youth council and also hold a youth "summit" to assist with transition issues. //2008//

/2010/ Carol Grady is a consumer member of the MCH Advisory Task Force. A former journalist, she became a nurse after the birth of a child with a special health need and now works in a NICU at a children's hospital. She was selected to be the family delegate to AMCHP, and along with Title V staff, she attended the combined MCHB Partnership and annual AMCHP meetings in the Spring of 2009.//2010//

Several staff are also parents with one or more children who have a special health care need. The roles these parents perform and the positions they occupy in the program include supervisory, policy and program planning, and technical consultation for statewide programs.

E. State Agency Coordination

Collaboration and coordination is a fundamental value and strategy for the work of Title V. It is essential to the accomplishment of our goals. Many of the earlier sections of this report as well as the Performance Measure narratives describe multiple partnerships between Title V, other MDH program areas, other state agencies, community-based entities, and local public health. These relationships are both long-standing, and also include some exciting new opportunities. Some of these are formal with MOUs and MOAs in place, and many are less formal.

INTRA-AGENCY COORDINATION

Office of Rural Health and Primary Care Minnesota's Title V and Primary Care Office (PCO) programs support each other's mission and the goals and objectives of their respective SSDI and Cooperative Agreement (CA) grants. The mission of the PCO is to improve access to preventive and primary care services for underserved Minnesotans. The Title V program works, in part, to further efforts of organizations that deliver health services to mothers and children and to provide leadership for statewide maternal and child health issues. Both programs promote the development of community-based, family-centered, comprehensive, coordinated, and culturally competent systems of services as a priority. The MCH Mental Health Coordinator is working closely with the Rural Health Advisory Committee on their priority for the year -- mental health issues in rural Minnesota. Focus areas include resources and provider capacity, and system issues rural Minnesota in the area of mental health. /2007/ Current focus areas include the ageing population, E-health and telemedicine. The Office of Rural Health and Primary Care was also assigned the responsibility for the Dental Access Grants. These funds support innovative clinical training for dental professionals and programs, which increase access to dental care for underserved populations. Approximately $1.5 million is available each year to support partnerships between dental training programs and safety net providers, including local public health agencies. //2007// /2009/ The Office of Rural Health and Primary Care has worked closely

with the Division of Community Health and Family Health over the last year on a number of oral health initiatives including: applying for a HRSA oral health worforce grant, supporting a Minnesota Oral Health Summit conference, and working on a state oral health plan. //2009//

The Office of Minority and Multi-Cultural Health (OMMH) relies on Title V staff for specific program area expertise for the Eliminating Health Disparities grantees, and Title V staff likewise rely on OMMH staff for access, guidance and assistance in their work with ethnic/cultural activities and groups. These partnerships have produced several joint trainings, conferences and other projects. Title V continues its leadership and commitment to support work with American Indians in Minnesota. The Title V Coordinator and other key Title V staff work closely with the MDH Tribal Health Liaison on planning for and attending quarterly Tribal Health Directors meetings, supporting internal department-wide meetings on American Indian health; traveling together on site visits to reservations; and providing information, resources and support for the American Indian Health Grants made directly to Tribes in Minnesota. /2008/ The OMMH has recently been moved into the same Bureau as the Division of Community and Family Health facilitating additional opportunities for intra-agency coordination. //2008// /2009/ Recent joint efforts have focused on an American Indian Infant Mortality Review project. This activity examined American Indian infant deaths (within the first year of life) that occurred in 2005 and 2006. Information for case summaries was obtained from birth and death records, health records, autopsy reports as well as interviews with mothers. Qualitative and quantitative data were combined to create a comprehensive picture of each infant death which was then reviewed by an expert panel, representing a cross section of professionals and key community representatives. //2009// ***/2010/The Governor proposed and the Legislature supported additional funding for the Behavioral Risk Factor Surveillance Survey to be able to increase sample size to allow for comparison results across racial/ethnic categories.//2010//***

Tobacco Prevention and Control Program (TP&C) and Title V MCH Section staff continue to work together to address tobacco prevention among children and families in Minnesota, with a growing focus on smoking cessation for pregnant women. Staff from both sections partner in the Robert Wood Johnson/ ACOG/Planned Parenthood project.

Center for Health Statistics (CHS) staff work on numerous projects with Title V staff, including data analysis, data and systems planning, training and presentations, and consultation. While the Title V Coordinator is the Principal Investigator for PRAMS in Minnesota, the day-to-day administration takes place in CHS, and the PRAMS steering committee includes staff from both Divisions. Joint activities are underway include matching birth certificate information, newborn screening information, and the upcoming Birth Defects Information System (BDIS). /2008/ Responsibility for PRAMS was moved to the Division of Community and Family Health. //2008// /2009/ CHS continues to play a key role in providing birth and death data for the block grant. They are currently partnering with the Home Visiting program to provide evaluation services and because of their expertise with large data bases are coordinating the matching of WIC and birth certificate data. //2009// ***/2010/ MCH staff worked closely with the Center for Health Statistics on the publication: Disparities in Infant Mortality released in January 2009. Current discussions are underway with both the Center and the Department of Human Services on collaborating on a Teen Pregnancy publication to be tentatively released sometime next year.//2010//***

The Division of Environmental Health houses several program areas on which Title V has been and continues to be priority partners, including the BDIS, lead programs, and work on children's environmental health. The state Public Health Laboratory and Title V staff work in tandem on the newborn bloodspot and hearing screening programs in planning, administration, education and training, monitoring, evaluation and follow-up. Routine newborn screening meetings are held with management staff from both Divisions. /2009/ Responding to consumer concerns, the MCH Section and the Division of Environmental Health worked closely to get accurate information out to the public about BPA in baby bottles this year. //2009// ***/2010/ During the 2009 legislative session, BPA was banned from "children's products", defined as bottles and cups,***

pacifiers, and teething rings designed to be used by children under 3 years of age, applicable to manufacturers and wholesalers by January, 2010, and retailers by January, 2011.//2010//

Ongoing relationships exist between Title V staff and several other program areas in MDH that generally enhance the work of both partners and frequently produce special short-term projects or activities. These areas include the immunization program, injury prevention, nutrition (outside of WIC), sexual violence prevention, STI / HIV prevention, and as described elsewhere, and the women's health team, /2007/ as well as the mental health team and adolescent health team //2007// convened and supported by Title V but drawing it's members from across the department.

INTER-AGENCY COORDINATION
Department of Human Services (DHS): The Title V programs and the Department of Human Services (the state's designated Title XIX and Title XXI agency) have a long history of collaboration framed by a formal interagency agreement. See Title V-Title XIX Interagency Memorandum of Understanding . Current collaborative efforts include the Family Service Collaboratives and the Children's Mental Health Collaboratives. DHS is represented on the MCH Advisory Task Force in an Ex-Officio status and Title V participates on the Medicaid Advisory Task Force. Numerous other activities are noted throughout this application. Formal contracts exist which provide DHS funding for staff in Title V programs relative to EPSDT, home visiting and services to deaf, hard of hearing, and deaf-blind individuals. Management and Executive Office staff of MDH and DHS meet on a quarterly basis to discuss issues of mutual interest and concern. Minnesota has several early childhood programs administered by DHS and representatives of these programs were involved in the MECCS grant (Minnesota's State Early Childhood Comprehensive Statewide Systems grant). Title V staff are important partners with DHS involved in the ABCD II grant, aimed at strengthening services and systems that support the healthy mental development of young children. /2008/ Through a formal Interagency Agreement, Title V funds are used to support 1.5 epi staff at the DHS. Based on jointly identified priorities, these staff have access to the DHS data warehouse for research activities. Current focus is determing if cost savings can be attributed to care coordination within a medical home setting. //2008// ***/2010/ While discussions are underway future focus on joint efforts may be teen pregnancy.//2010//***

Department of Education The Title V program and the Department of Education (DOE) collaborate on many projects and programs: Family Service and Children's Mental Health Collaboratives, Part C, Early Childhood Screening, pregnancy prevention and abstinence education programs, Fitness Fever, Minnesota Healthy Beginnings, service coordination (for ages 3-21), third party billing, a children's advocate group, and a grant advisory board regarding children with special health care needs and child care. There is active collaboration between DOE and MDH on the Minnesota Student Survey, including Title V staff. In State Fiscal Year 2004, the CYSHCN program expanded its Interagency Agreement with MDE to include Part B as well as Part C (of IDEA) responsibilities.

The DOE is the lead agency in Minnesota for the Early Childhood Intervention Program (Part C); a joint initiative of three state agencies: (Health; Human Services; and Education) and local IEICs (Interagency Early Intervention Committees). Through an interagency agreement, the Department of Health receives funding for specific activities and staff within the CYSHCN program. As part of the Part C activities, staff actively participate on the mandated State Agency Committee (SAC) and the Governor appointed Interagency Coordinating Council (ICC). The Department of Health's Part C team provides outreach, information, training, and technical assistance on health related early childhood topics and issues to families; state, regional, and local health, education, and human service agencies; public and private providers and IEICs (Interagency Early Intervention Committees). The team has primary lead for public awareness/child find; ongoing technical support of the Follow Along Program (tracking system for identifying children at-risk); a statewide information and assistance line (central directory

requirement); establishing and maintaining an interagency data system; and providing training and technical assistance on managed care issues, health benefits coordination, and outreach to health care providers on Minnesota's early childhood intervention system.

Department of Corrections: The Department of Corrections participates with MDH, DHS, and Minnesota Department of Education on children's mental health issues in the state. This relationship has been long standing and children's mental health issues provide avenues and linkages to address children's mental health issues in juvenile correction centers. Title V staff also collaborate with the Minnesota Department of Corrections on adolescent health issues through the Interagency Adolescent Female Subcommittee (IAFS). This is a subcommittee of the Department of Correction's Advisory Task Force for Female Offenders in Corrections. The MCH Adolescent Health Coordinator is a member of the IAFS and provides the adolescent health perspective to its work, assuring gender-specific programming for girls in corrections.

Children's Mental Health Collaboratives: The primary focus for children's mental health in Minnesota is the development of a community-based, unified system of services for the child and family. The Comprehensive Children's Mental Health (CCMH) Act requires that counties provide a specified array of mental health services to children. The CCMH Act establishes guidelines for development of Children's Mental Health Collaboratives including integration of funds in order to use existing resources more efficiently minimize cost shifting and provide incentives for early identification and intervention. This focus on early identification and intervention gives increased importance to public health agency efforts and expands opportunities for coordination with other services. Local partnerships with social services, corrections, and education agencies create integrated systems that improve services to children with mental health problems and provide services for their families.

Family Service Collaboratives: Family services collaboratives were initiated in 1993 by the Minnesota legislature which mandated public health's involvement, recognizing the vital role public health plays in assessing and addressing the health of all mothers and children in communities and the state. Included in this initiative were collaboration grants to foster cooperation and help communities come together to improve results for Minnesota's children and families. By providing incentives for better coordination of services, Minnesota hoped to increase the number and percentage of babies and children who are healthy, children who come to school ready to learn, families able to provide a healthy and stable environment for their children and children who excel in basic academic skills. Recognizing that no single funding source alone is responsible for changing outcomes, a set of statewide core outcomes was distilled from the collaboratives' efforts. Promoted across systems in 1998, this list has been included in the work of the Family Support Minnesota formerly the STATES Initiative, the KIDS Data Project, and Minnesota Healthy Beginnings, among others. Many of these outcomes and their indicators align with the federal/state MCH performance measures; and many others offer future directions for development of measurement tools, in particular, those with the promotional perspectives of family support.

Coordinated System for Children with Disabilities Aged Three to 21 -- involving multiple state agencies: State law mandates a coordinated interagency system for children from three to 21 with disabilities, as defined by IDEA. CYSHCN staff have been actively involved with an 18 member State Interagency Committee made up of seven state agencies and other participants for oversight of this planning, as well as numerous workgroups creating the guidance for this system at both the state and community level.

University of Minnesota: Collaboration between the Title V programs and the University of Minnesota School of Public Health continues on various research, evaluation and training projects. The MCH program within the School of Public Health holds an Ex-Officio position on the Maternal and Child Health Advisory Task Force. The Department's Title V program collaborates with the school's MCH program community education activities including presenting at its annual summer Institute. A number of MPH students have their internships in the Division of Community

and Family Health, and several Title V program staff are graduates of the program. Faculty from the University have provided training and technical assistance to Title V staff through informal communications as well as some sessions--particularly as part of the building capacity activities underway over the past two years. The MCH Adolescent Health Program collaborates extensively with the University of Minnesota Konopka Institute for Best Practices in Adolescent Health, Division of General Pediatrics and Adolescent Health. This partnership focuses on building the capacity and skill of adolescent-focused programs across the state. MCH Reproductive Health staff collaborate with the National Teen Pregnancy Prevention staff at the University of Minnesota on numerous projects including the implementation of the state teen pregnancy prevention and parenting plan. The CYSHCN program serves as mentors for each of the students in the University of Minnesota School of Nursing program emphasizing CYSHCN. In addition, CYSHCN program, the School of Public Health and the Center for Urban and Regional Advancement (CURA) of the Humphrey Institute (University) worked together to evaluate MCSHN Developmental Behavior Clinics. The University of Minnesota receiving status as an Academic Center of Excellence in Women's Health has brought opportunities for enhanced relationship and shared activities. This dual partnership has also extended to include the Community Center of Excellence at an urban Minneapolis clinic. MCH epidemiology staff from the University were helpful in planning, recruiting, and hiring for a new MCH Epidemiologist position at MDH.

F. Health Systems Capacity Indicators

Introduction

One of our longstanding challenges in Minnesota has been the gap in birth outcomes between White and non-White populations. While MN's overall birth outcomes have been outstanding over the years, with one of the lowest infant mortality rates in the nation, our high White population has masked the consistently lower rates of non-White groups. In 2001, the Eliminating Health Disparities Initiative (EHDI) was established by the MN State Legislature. The primary goal of this initiative was to reduce the discrepancy in early infant death between White and non-White populations by 50% by 2010. Enlisting the input and participation of non-White groups was a primary strategy.

In January 2009, the MN Center for Health Statistics, along with the Maternal and Child Health Section of the Community and Family Health Division, released a new report titled: "Disparities in Infant Mortality." This report highlights recent accomplishments in this area. During a period when little progress in reducing infant mortality was seen at the national level (2001-2005), disparities between White infant deaths and Asian and Hispanic infant deaths in MN decreased by 75.0% and 66.7%, respectively. Thus, our 2010 goal for these two groups has already been met.

Further, disparities between White infants and African American and American Indian infants during this period decreased by 37.7% and 26.3%, respectively. While we fell short of our target goal with the latter two groups, substantial progress has been made and will continue to be made. The causes of infant mortality are complex and vary across racial and ethnic groups, rendering it impractical and ineffective to develop a single public health approach which fits all populations.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	33.6	25.9	27.5	31.2	
Numerator	1073	846	885	1046	
Denominator	319809	326227	322047	335694	

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008
2008 data not yet available.

Notes - 2007
2007 data not yet available

Notes - 2006
The 2006 data are not yet available.

Narrative:
The annual rates for asthma hospitalizations among children less than five years of age increased monotonically from 2001-2004, reaching a peak of 33.6 per 1,000 in 2004, followed by a decline to 25.9 per 1,000 in 2005. Without additional data, we are unable to conclusively explain the patterns observed in the data. Within a given year, asthma hospitalization rates typically show seasonal variations, with a relatively large peak in the fall, followed by a decline and leveling out until the spring, when they show a second smaller peak. Anecdotally, respiratory viruses (i.e., RSV and influenza) and pollens are thought to trigger the fall and spring peak rates of asthma hospitalizations, respectively. Dramatic temporal variations, such as the peak rate of 33.6 per 1,000 during 2004, might be the result of a virulent strain of respiratory virus and/or exceptionally high levels of pollens or other environmental contaminants (e.g., air pollution). Alternatively, large changes in rates might just be a statistical anomaly. Indeed other MDH staff report that Asthma Program data (not shown) suggest that hospitalization rates for children in Minneapolis and St. Paul have decreased over this time period.

The MDH is continuing to identify areas of need, including ‘pockets' of higher rates based on geographic location, insurance status, ethnicity, or socio-economic measures. Most recently, in 2007, the MDH in collaboration with stakeholders updated a "Strategic Plan for Addressing Asthma in Minnesota." Supported by a grant from the Centers for Disease Control and Prevention (CDC) and in collaboration with a wide range of partners, the MDH has been implementing a comprehensive set of strategies identified in the original strategic plan. Strategies include expanding and evaluating data collection to better estimate the prevalence and morbidity of asthma in MN; creating better awareness of asthma; providing asthma education to health professionals; and developing public policies to reduce exposure to environmental triggers of asthma. The goal of the plan is to reduce hospitalizations and emergency room visits due to asthma and to improve the lives of those who live with asthma. Although the work of the Asthma Program is not specific to children, it has a significant impact on children with asthma. The Title V programs will continue to work closely in collaboration with the MDH Asthma Program.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	87.3	87.0	85.1	87.0	86.9

Numerator	46819	48467	26114	27667	28006
Denominator	53617	55707	30669	31790	32232
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2006
The 2006 data are not yet available.

Narrative:
Title V staff from both MCH and CYSHCN programs work closely with staff from the Medicaid program (administered by the Department of Human Services) to support continual improvements in this measure. The MCH program is under contract with the Department of Human Services to provide training of providers who implement Minnesota's EPSDT program, which is called Child and Teen Check-up (C&TC). Trainings specific to administering C&TC are provided to health care providers, and include onsite follow-up consultations and clinic flow assessment. Information is sent to local public health staff regarding C&TC rates in their communities so they can adjust their outreach strategies.

Trainings are also provided to local public health nurses, school nurses, county workers and others about the Medicaid application process and strategies to enhance outreach activities to ensure utilization of preventive services for Medicaid enrolled infants and children. As an example, the Family Home Visiting program administered by MCH, has as one of its outcome measures, that children receive appropriate, timely and ongoing screening. From a broader perspective, there are two existing collaborative activities currently underway focusing on early childhood screening: the Minnesota Early Childhood Comprehensive Screening (MECCS) grant and BUILD a multi-sector planning and advocacy group. Both are assessing needs and capacities, discussing and making recommendations for policy and systems changes to improve child find, screening, assessment and intervention. Additionally, as part of accountability and reporting of local public health agencies two outcome measures are relevant to this HSCI: 1). Increase the percentage of children ages 0-3 who are screened for developmental and social-emotional issues every 4-6 months; and 2). Increase the participation rate of Medicaid and MinnesotaCare enrolled children aged 0 to 21 who receive Child and Teen Check-ups.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	0	0	0	0	
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	

Notes - 2008
MN does not participate in this program.

Notes - 2007
Historically there are less than 100 children enrolled on SCHIP. Eligibility critieria is children under two whose family income is between 275 FPG and 280 FPG.

Notes - 2006
No changes in MN SCHIP anticipated for 2006.

Narrative:
SCHIP eligibility in Minnesota only covers infants 0 to 2 years, whose family income is between 275% and 280% of federal poverty. For this reason, there are very few children enrolled, making this measure non-applicable. MinnesotaCare, Minnesota's state subsidized insurance program was in place prior to federal enactment of SCHIP and MinnesotaCare eligibility at that time went to 275% of federal poverty limiting Minnesota's ability to take full advantage of the SCHIP legislation for coverage of infants and children.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	77.9	77.6	77.9	80.3	
Numerator	54844	54922	57101	59001	
Denominator	70426	70750	73300	73477	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008
2008 natality data not yet available.

Notes - 2007
2007 data not yet available

Notes - 2006
The 2006 data are not yet available.

Narrative:
While the number of women giving birth has increased over the past several years, the Kotelchuck Index has kept pace and even improved slightly. When one digs deeper into the numbers, however, there continue to be disparities in prenatal care for women who are non-White. Low health insurance rates for Hispanic women of child-bearing age, along with a growing number of undocumented immigrants, present challenges for assuring adequate prenatal care. Title V staff collaborate internally with the Office of Minority and Multicultural Health and externally

with local public health agencies, Twin Cities Healthy Start, and community clinics to increase these rates. In addition, the MN PRAMS project is now shifting focus to actively promote data analysis and the translation of "data into action." Upcoming analyses of the PRAMS dataset may shed light on the barriers to access to adequate prenatal care experienced by non-White women in MN, and help guide future policy and programming aimed at eliminating these disparities.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	87.6	79.3	79.2	77.6	89.0
Numerator	397000	361695	364416	364189	367309
Denominator	453000	456000	460000	469436	412709
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
2007 data is not yet available

Narrative:
Continued state efforts described under HSCI #02 will continue to encourage Medicaid enrollment and appropriate health care utilization. The 2007 Legislative Session also enhanced outreach efforts that will impact this indicator. Beginning July 1, 2007 new efforts will include toll-free telephone number for application assistance; application assistance requirements directed at county agencies, hospitals, community health care clinics, libraries, child care centers, school districts and others; and an application assistance bonus ($25 per application) for organizations.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	46.7	48.5	48.2	48.8	51.1
Numerator	33479	35728	36160	36814	39448
Denominator	71681	73680	75058	75490	77167
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2006
Based on State FY rather than on the CY.

Narrative:
While this indicator has shown improvement over the last five years, it continues to be worrisome that a significant number of Medicaid enrolled children are not receiving appropriate dental services. Minnesota's Medicaid program provides a comprehensive dental benefit set for children. However, challenges continue in locating a provider, especially in rural Minnesota, that will either accept or take new Medicaid patients. Significant legislative attention has created a number of initiatives over the years designed to improve access to services. These include increasing reimbursement fees, collaborative agreements allowing dental hygienists to assume additional responsibilities, dental loan forgiveness programs for working in dental shortage areas, and grants that allow innovative approaches to providing services to underserved populations. During the 2007 Legislative Session add-on payments for critical access dental providers serving Medicaid clients was continued and one time funding of $500,000 was targeted to dental services in Minneapolis, Beltrami and St. Louis Counties.

Minnesota was awarded in 2008 both a CDC Oral Health Infrastructure Grant and a HRSA Oral Health Workforce Grant. Activities and funding available under these two grants will assist in building the necessary infrastructure in Minnesota to improve the oral health of our most vulnerable populations, including our Medicaid enrolled children.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	8471	9046	9541	10264	11337
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
2007 data not yet available

Notes - 2006
The 2006 data are not yet available.

Narrative:
Almost all children and youth on SSI in Minnesota are eligible for Medicaid. In Minnesota, Medicaid provides a comprehensive package of services including rehabilitative services, thereby negating the role of the Minnesota's CYSHCN program in providing these services. While not providing direct rehabilitative services, the CYSHCN program in Minnesota does contact families who apply for SSI to assure families know about Medicaid eligibility and other options that may be available to them. This is also an opportunity to answer general questions and assist families as needed.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2007	matching data files	7.9	6.1	6.8

Narrative:
Low birth weight rates has been increasing for both Medicaid and non-Medicaid births. As occurs with many of Minnesota's data, there are disparities in these populations based on race/ethnicity -- and also for younger mothers. Because there are higher rates of women of color and teen moms enrolled on Medicaid, this higher rate for low birth weight would be expected. It is anticipated that Minnesota's efforts in reducing infant mortality will also impact low birth weight rates.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2006	matching data files	6.8	4.1	5.1

Narrative:
Rates of infant death have decreased for both the Medicaid population and for the non-Medicaid population with the Medicaid decrease being the larger of the two. Care must be used however, in interpreting these changes as the number of infant deaths is small.

Title V staff continue to work with the Office of Minority and Multicultural Health on reducing the disparities in infant mortality between Whites, American Indian, and populations of color. The target of reducing by 50% the gap in infant mortality rates between ethnic and racial groups and whites established by the 2001 Legislature has been met for Latinos and Asians. Yet, while infant mortality rates have declined noticeably for African Americans and American Indians disparities between these two groups and Whites continue to exist. Reducing disparities in infant mortality continues to be a priority for the Department of Health.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL

MCH populations in the State					
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	matching data files	76	91.5	85.8

Narrative:
Women on Medicaid continue to start prenatal care later than non-Medicaid women. The MN PRAMS project is now shifting focus to actively promote data analysis and the translation of "data into action." Upcoming analyses of the PRAMS dataset may shed light on the barriers to access to adequate prenatal care experienced by non-White women in MN, and help guide future policy and programming aimed at eliminating these disparities.

The Maternal and Child Health section in partnership with the University of Minnesota and the March of Dimes is holding a preconception conference in the fall of 2007, called "A Lifespan Approach to Reproductive Health: Getting it Right". Topics of the conference include: successful models of preconception care, systems challenges and opportunities, genetics and teen health. This effort will be a first step in working to assure efforts in Minnesota are focused on assuring women are healthy prior to pregnancy.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2007	matching data files	75	83.5	80.3

Narrative:
Kotelchuck Index rates continue to be a concern particularly for our Medicaid population. Significant attention is being placed on improving pregnancy outcomes, especially for Minnesota's racial and ethnic populations, during the upcoming year. In addition, we are trying various strategies to be more successful in over sampling racial and ethnic communities in our PRAMS survey to provide additional insight as to the issues facing these communities.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	280

INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Infants (0 to 1)	2007	280

Narrative:
Minnesota's Medicaid program goes to 275% of poverty level for infants 0 to 1 years of age. Minnesota's SCHIP program eligibility is between 275% and 280% resulting in very few infants on SCHIP.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children (Age range 1 to 2) (Age range 2 to 18) (Age range 19 to 21)	2008	 280 150 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 2) (Age range to) (Age range to)	2007	 280

Narrative:
There are three populations that are eligible for SCHIP in Minnesota. They are 1) infants under 2 who are at or below 275 -- 280% of poverty; 2) Non-citizen, pregnant women, not eligible for Medicaid due to immigration status, who are at or below 275% of poverty; and 3) MinnestoaCare (Minnesota's state sponsored health insurance program) parents who are at or below 100-200% of poverty.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2008	275
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women		

Notes - 2010
Pregnant women and children over age two do not participate in the SCHIP program in MN.

Narrative:
Approximately 34% of all births in Minnesota are to women who are enrolled on Medicaid. SCHIP eligibility only includes: non-citizen, pregnant women, not eligible for Medicaid due to immigration status whose income is at or below 275% of federal poverty level.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	No
Annual linkage of birth certificates and WIC eligibility files	3	No
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	No
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2010

Narrative:
With the establishment of a focused Title V Data/Epi Unit, which now includes 7 FTEs, our capacity in this area continues to improve. Through the SSDI grant activities, relationships with WIC are more productive and linkages with WIC data with Birth and Medicaid files will occur this year. The Data Integration Workgroup continues to work on data compatibility between newborn bloodspot and hearing screening, vital records, and is working with immunizations, birth defects registry and lead screening. The Data/EPI Unit are actively involved in projects with birth defects registry, FAS surveillance, the Follow Along Program, PRAMS, Newborn Hearing Screening and the Family Home Visiting Program. Discussions are underway around enhanced interoperability of child health information systems -- both within MDH and with external partners, including local public health. Shared data positions between Title V programs and Medicaid has significantly

improved Title V access to Medicaid data, and further enhanced partnership between the two agencies around Title V issues and program areas.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	1	No
MN Student Survey	2	Yes
MN Youth Tobacco Survey	2	Yes

Notes - 2010

Narrative:
Minnesota does not participate in the Youth Risk Behavior Survey. Minnesota data on youth is obtained through the Minnesota Student Survey which is administered every three years to 6th, 9th and 12th graders. In response to the question regarding cigarette smoking in the 2007 survey, data indicates a continued downward trend across all three age groups. After increasing the early 1990's, the smoking rates among 12th graders dropped from 42.1% in 1998 to 23% in 2007. The 6th and 9th grade reported smoking rates have declined
slightly between 1995 adn 1998, and then the rates started declining precipitously; they were cut more than three quarters among 6th graders (from 7.0% in 1998 to 1.5% in 2007) and by about two thirds among 9th graders (from 29.9% in 1998 to 10.4% in 2007). Although more than one in five 12th graders till reported smoking cigarettes in the past month, these are the lowest rates reported in the history of the Minnesota Student Survey.

IV. Priorities, Performance and Program Activities

A. Background and Overview

/2007/ The 2005 needs assessment identified ten new state priorities. The MCH Advisory Task Force over the last year has worked to identify specific strategies to effectively move Minnesota forward in attaining our annual performance objectives. These recommendations covering all three of the MCH populations will be submitted to the Commissioner of Health this fall for consideration. Both Title V programs have begun the important work of incorporating the priorities into their daily work as noted in the discussion of National and State Performance Measures, their Activity Tables and in other areas of this application. Minnesota's priorities are broad-based and encompass significant maternal and child health, including children with special health care needs, issues. The ability to impact these priorities will require close partnerships be maintained with local public health, other state agencies, such as the Department of Human Services (the designated Medicaid and Mental Health Authority) and the Department of Education (lead agency for Part C), with advocacy organizations such as PACER and the Minnesota Organization for Adolescent Pregnancy Prevention and Parenting, with professional organizations such as the Minnesota Dental Association, AAP Minnesota Chapter, and ACOG, as well as other areas in the Department of Health such as the Office of Minority and Multicultural Health. As detailed in other areas of the application these relationships have been established and there is a long history of working together for common goals. The following measures either met or exceeded the target, based on the most recent data available: NPM 1 -- newborn blood spot screening NPM 17 -- VLBW births at high-risk facilities OM 3 -- neonatal mortality rate. Improvement was made on the following performance measures, although the target was not met: NPM 7 -- immunization rates NPM 9 -- third graders with a dental sealant on at least one molar NPM 10 -- motor vehicle accidents of children 14 years or younger NPM 12 -- newborn hearing screening OM 4 -- post-neonatal mortality rates. Measures were maintained, but the target was not met on these following measures: NPM 16 -- youth suicide NPM 18 -- infants born to mothers receiving care in first trimester OM 1 -- infant mortality rate OM 6 -- child death rates. Measures that worsened and will require further focused effort or data analysis: NPM 8 -- teen pregnancy prevention; NPM 13 -- children without health insurance; OM 2 -- black to whit ratio of infant mortality; OM 5 -- perinatal mortality rates. The remaining measures are either based on SLAITS for children with special health needs or are new measures and as such have no new comparison data. //2007//

/2008/ Based on the most recent data available, Minnesota met, exceeded or made progress in meeting the target for the following measures: NPM 01 Percent of screen positive newborns who received timely follow-up
NPM 08 The rate of birth for teenagers NPM 09 The percent of third grade children who received protective sealants NPM 10 Rate of deaths to children caused by motor vehicle crashes NPM 11 Percent of mothers who breastfeed their infants at 6 months NPM 14 Percentage of children on WIC with BMI at or above 85%
NPM 17 Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
SPM 01 Proportion of counties that universally offer Follow-Along Program SPM 02 Percent of children who receive EPSDT SPM 10 Degree to which mental health screening, evaluation, and treatment is provided to CYSHCN. Based on the most recent data available, Minnesota did not make progress in meeting target for the following measures: NPM 07 Percent of infants who have received all age appropriate immunizations NPM 12 Percent of newborns screened for hearing NPM 16 Rate of suicide deaths among youths NPM 18 Percent of infants born to pregnant women receiving prenatal care in first trimester SPM 04 Incidence of determined cases of child maltreatment SPM 08 Ratio of lbw rate for American Indian women and women of color to the low birth rate for white women. The remaining measures are based either on SLAITS data or have no new comparison data available. //2008//

/2009/ Based on the most recent data available, Minnesota met, exceeded or made progress in

meeting the target for the following measures: NPM 01 Percent of screen positive newborns who received timely follow-up.
NPM 02 Percent of CSHCN whose families partner in decision making. NPM 03 Percent of CSHCN who receive care within a medical home. NPM 05 Percent of CSHCN whose families report community-based services.
NPM 06 Percent of CSHCN who received services necessary to make transitions. NPM 10 Rate of deaths to children caused by motor vehicle crashes. NPM 11 Percent of mothers who breastfeed their infants at 6 months of age. NPM 13 Percent of children without health insurance. NPM 14 Percentage of children on WIC with BMI at or above 85%. NPM 15 Percentage of women who smoke in the last three months of pregnancy. NPM 16 Rate of suicide deaths among youths. NPM 18 Percent of infants born to pregnant women receiving prenatal care in first trimester. SPM 02 Percent of children who receive EPSDT. SPM 03 Percent of sexually active ninth grade students who used a condom at last intercourse. SPM 04 Incidence of determined cases of child maltreatment. SPM 06 Percent of pregnant women screened for depression during routine prenatal care.
SPM 07 The degree Title V programs enhance statewide capacity for a public health approach to mental health for children and adolescents SPM 08 Ratio of low birth weight rate for American Indian women and women of color to the low birth rate for white women. SPM 09 Percent of CSHCN with one or more unmet needs for specific health care services. SPM 10 Degree to which mental health screening, evaluation, and treatment is provided to CYSHCN. NOM 02 The ratio of the black infant mortality rate to the white infant mortality rate.
NOM 05 The perinatal mortality rate per 1,000 live births plus fetal deaths. NOM 06 The child death rate per 100,000 children aged 1 through 14. Based on the most recent data available, Minnesota did not make progress in meeting targets for the following measures: NPM 04 Percent of CSHCN whose families have adequate insurance. NPM 07 Percent of infants who have received all age appropriate immunizations. NPM 08 The rate of birth for teenagers. NPM 09 Percent of third grade children who have received protective sealants on one permanent molar. NPM 12 Percent of newborns screened for hearing. NPM 17 Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates. SPM 01 Proportion of counties that offer a tracking program for birth to age to three. SPM 05 Percent of pregnancies that are intended. NOM 01 Infant mortality rate per 1,000 live births. NOM 03 The neonatal mortality rate per 1,000 live births. NOM 04 The post neonatal mortality rate per 1,000 live births. //2009//

/2010/ Since last year, Minnesota met, exceeded or made progress in meeting the performance objectives for the following measures: NPM 01: Percent of screen positive newborns who received timely follow-up. NPM 07: Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations. NPM 09: Percent of third grade children who have received protective sealants on at least one permanent molar tooth. NPM 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children. NPM 12: Percentage of newborns who have been screened for hearing before hospital discharge. NPM 13: Percent of children without health insurance. NPM 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates. SPM 02: Percent of children enrolled in Medicaid who receive Early Periodic Screening, Diagnosis, and Treatment (EPSDT). SPM 03: Percent of sexually active ninth grade students who used a condom at last intercourse. SPM 04: Incidence of determined cases of child maltreatment by persons responsible for a child's care. SPM 06: Percent of pregnant women screened for depression during routine prenatal care. SPM 07: The degree to which Title V programs enhance statewide capacity for a public health approach to mental health promotion and suicide prevention for children and adolescents. SMP 10: Degree to which comprehensive mental health screening, evaluation, and treatment is provided to Children and Youth with Special Health Care Needs. //2010//

B. State Priorities

This section describes the relationships between the new state priorities from the recently completed 2005 needs assessment and several measures: the national performance and outcome measures, Health System Capacity Indicators, Health Status Indicators, Minnesota's state priorities from the previous 5 year cycle, and some of the statewide outcomes for Minnesota's developing Local Public Health Grant (LPHG) activities. These LPHG statewide outcome measures are newly developed and work is currently underway to establish the reporting system through which these measures will be reported by local public health agencies to MDH. These priorities are in no particular order. /2009/ These state priorities identified in Minnesota's 2005 Needs Assessment process continue to be the focus of Title V activities. //2009//

Priority 1 -- Improve early identification of and intervention for CYSHCN -- birth to three years. Early identification, screening and referral systems identify children's strengths as well as their needs. These systems can maximize healthy child development and minimize adverse health, social and emotional incidents. Universal screening of all children, birth to age three--regardless of perceived risk factors--promotes thorough identification of those with special health care needs and subsequent provision of intervention services to children who are eligible under Part C of Individuals with Disabilities Education Act (IDEA). This priority is related to NPM 1 - newborn screening, NPM3 - medical home, NPM5 -- services being organized for easy use, NPM12 -- newborn hearing screening, HSCI #2 & 3 children on Medicaid and MinnesotaCare who received at least one initial or periodic screening, and the new statewide outcome for essential local public health activity #19 -- Increase the percentage of children ages birth-3 who are screened for developmental and social emotional issues every 4-6 months. This state priority is essentially the same as the priority from the last 5 year cycle to assure early identification and intervention for young children.

Priority 2 -- Assure that children and adolescents receive comprehensive health care, including well child care, immunizations, and dental health care. Well-child care reduces long-term costs by encompassing a variety of health promoting/disease preventing services and by providing opportunities to detect and treat health conditions early. Within the Medicaid population, as in the entire population of children and adolescents in Minnesota, incidence of chronic disease is growing - particularly childhood obesity, diabetes, asthma, mental health disorders, and injuries. Prevention and health education services, and early detection and treatment may assist in reversing this trend. This state priority is related to NPM 1 -- newborn screening, NPM 4 -- adequate insurance, NPM 7 -- immunizations, NPM 9 -- 3rd graders with protective sealant on molar, NPM 12 -- newborn hearing screening, NPM 13 -- children without insurance, NPM 14 -- BMI index at or above 85th percentile, HSCI#1 -- asthma hospitalizations, HSCI#2 -- MA enrollees receiving at least one initial or periodic screen, HSCI#6 -- FPL eligibility for MA, HSCI #7B -- EPSDT children receiving dental service, and the new statewide outcome for essential local public health activity #24 increase the percentage of 2 year olds that have been age appropriately immunized.

Priority 3 -- Prevent teen pregnancy and sexually transmitted infections. Teen pregnancy has been steadily decreasing in recent years but has reached a plateau in Minnesota, while STIs have continued to increase among females and among adolescents and young adults, with significant disparities among some racial/ethnic groups. If undetected and untreated, these STIs can lead to other severe health issues and possibly infertility. This priority is related to NPM8 -- teen birth rate, HSI#05a Chlamydia rate for females 15 to 19, and the new statewide outcome for essential local public health activity #13 decrease the rate of births/pregnancies to adolescents ages 15-17.

Priority 4 -- Prevent child abuse and neglect. Child maltreatment is among the most prevalent and far-reaching forms of violence in Minnesota. All four maltreatment types (neglect, physical abuse, sexual abuse, mental/emotional injury) are represented here. Further, child and

adolescent maltreatment often precedes adult violence and substance misuse/addiction as the abused child grows older. This is a repeated state priority from the last 5 year cycle and is related to the new statewide outcome for essential local public health activity #21 - reduce the rate of maltreatment and sexual abuse of children ages birth to 17 years olds.

Priority 5 -- Promote planned pregnancies and child spacing. Pregnancies which are intended and/or planned will likely result in improved health outcomes, lower occurrence of perinatal/postpartum depression, fewer abortions, decreased child maltreatment and other negative outcomes for pregnant women, infants and children. Access to family planning is critical to achieve this goal. This priority is a repeat from the last 5 year cycle and is related to NPM8 - teen birth rates, NPM 18 - early prenatal care, HSI#1 -- low birth weight births, and is related to the new statewide outcome for essential local public health activity #13 decrease the rate of births/pregnancies to adolescents ages 15-17.

Priority 6 -- Assure early and adequate prenatal care. Minnesota records approximately 70,000 births annually with an estimated 1.1 million women of childbearing age. The percent of women who met the Kotelchuck Index has been increasing slowly and for 2003 is at 77.5 percent. Women with late or no prenatal care are unlikely to receive the services that promote early identification of problems and the healthiest birth outcome possible. There are continuing racial/cultural and economic disparities in rates of adequate prenatal care. This priority is related to several other measures of prenatal care -- NPM18, HSCI#4, HSCI#5; to 5 of the 6 outcome measures related to infant mortality, as well as HSCI#05b re: infant mortality for MA and non-MA; to birth weights -- NPM 15, HSCI#5, HSI#1, HSI#2; and is related to the new statewide outcome for essential local public health activity #32 early and adequate prenatal care.

Priority 7 -- Promote mental health for children and adolescents, including suicide prevention. Mental disorders were the sixth leading cause of emergency room visits among 5-19 year olds in Minnesota and the leading cause of hospitalization for 5-14 year olds in 2001. From 1998-2002 suicide was the third and second leading cause of death for 10-14 year olds and 15-19 year olds, respectively. Disparities exist within some racial and cultural populations. This priority is related to NPM 16 -- suicide deaths among youth ages 15-19, and to several of the new statewide outcome for essential local public health activities: #14 -- reduce the rates of suicide; #15 -- reduce the rate of hospital-treated self-inflicted injuries; #16 -- increase the screening for mental health needs for children, adolescents, and children with special health needs; #18 -- increase the percentage of children birth to 3 who are screened for mental health and social emotional issues every 4 to 6 months.

Priority 8 -- Eliminate racial and ethnic health disparities impacting mothers and infants. There are substantial health disparities for pregnant women, mothers and infants in Minnesota. Many of these disparities are masked by the excellent health outcomes and very high proportion of our white population. Health disparities exist in birth weight outcomes, infant mortality, neonatal and perinatal mortality, maternal mortality, insurance status, adequacy of prenatal care, and numerous social and economic conditions that affect health. This priority is related to OM #2 -- ratio of black to white infant mortality, HSI#08 -- deaths of infants and children by racial subgroup, and to the new statewide outcome for essential local public health activity #1 increase the number of community health boards that assess disparities and social conditions that underlie health and address them in their action plans.

Priority 9 -- Improve access to care of children and youth with special health needs (including medical home, specialty care and services, oral health and that services are organized for easy use). CYSHCN often have multiple disabilities and service needs cutting across several areas. Thus it is critical to have access to a variety of specialized services, as well as oral health care. Of those children in Minnesota who needed specialty services in 2001, nearly 23,000 (14%) had one or more unmet needs, placing MN last in the Upper Midwest in meeting specialized service needs for CYSHCN. This priority is related to NPM 3 -- medical home, NPM 4 -- adequate insurance, NPM 5 -- families reporting community-based service systems are organized so they

can use them easily, NPM 6 -- services to support transition, NPM 9 -- 3rd graders with sealant on molar, NPM 13 -- children without health insurance, HSI#9 -- state health program enrollment, HSCI#1 -- asthma hospitalizations, HSCI#2 -- MA enrollees receiving at least one initial or periodic screen, HSCI#6 -- FPL eligibility for MA, HSCI#7 -- EPSDT children receiving dental service, and new statewide outcomes for essential local public health activities #33 -- families partnering in decision-making, #34 - families reporting organized services systems, and #35 -- increase clients enrolled in health insurance programs.

Priority 10 -- Improve access to comprehensive mental health screening, evaluation, and treatment of CYSHCN. Anxiety, depression (including suicidal thoughts) and other mental disorders often occur among CYSHCN. In addition, CYSHCN are highly vulnerable to maltreatment, including neglect and physical, sexual, and mental abuse. Early identification of and intervention for mental health issues are critical in this population. Having health insurance can influence access to mental health services thereby creating a relationship between this priority and all the insurance measures: NPM 4 -- CYSHCN with adequate insurance, NPM 13 -- children without insurance, HSCI#6 -- FPL eligibility for MA, and HSI#9 -- state program enrollment. This priority also relates to NPM 16 -- youth suicide deaths, HSI#3 -- deaths due to injury, HSI#4 -- nonfatal injury, and to the new statewide outcomes for essential local public health activities #14 suicide rates, #15 hospital treated self-inflicted injuries, #16 increase the screening for mental health needs for adolescents, children with special health needs and pregnant and postpartum women, and #35 -- increase the number of clients who are enrolled in health insurance programs.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	74	141	141	142	149
Denominator	74	141	141	142	149
Data Source					MDH Newborn Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2008
Data from the Newborn Screening Program

Notes - 2007

2007 data not yet available

Notes - 2006
2006 data not yet available.

a. Last Year's Accomplishments
The percentage of newborns screened in calendar year 2008 was 99.4 percent with 71,728 infants screened during this time period. There were 762 presumed positive screening results and 149 confirmed positive results, including Amino Acidemias (9), Biotinidase Deficiency (7), Congenital Adrenal Hyperplasia (4), Congenital Hypothyroidiism (48), Cystic Fibrosis (13), Fatty Acid Oxidation Disorders (19), Galactosemia (8), Hemoglobinopathies (21) and Organic Acidemias (20). The breakdown of infants not screened includes 89 infants with parent(s) refused screening for the infant and 184 infants who died.

The Newborn Blood Spot Screening Program tests samples taken from newborns, notifies the primary physician of positive test results, tracks the results of confirmatory testing and diagnosis and links families with appropriate resources. This MDH program is operated as a partnership between the Public Health Laboratory Division and the Title V-CSHCN program.

Short term tracking (prior to point of confirmatory diagnosis) became the responsibility of the Public Health Lab in April of 2008 with Lab staff providing education and information to the provider community. Roles and responsibilities were defined for short and long term follow-up activities for newborn blood spot and newborn hearing screening. The goal is to work toward a system of integrated data management and improved services to families. Resources available for families included primary care practitioners, pediatric specialists, genetic counseling, high risk public health follow-up programs, early education, WIC, and financial health care coverage through programs such as Medical Assistance, MinnesotaCare and others. Follow-up includes collaborating with the University of Minnesota to successfully maintain a multidisciplinary clinic for individuals with congenital adrenal hyperplasia and associated conditions. Other activities occurring in this time frame include the provision of an up-to-date web-based list with recommended medically prescribed formulas and pharmacotherapy agents for inborn errors of metabolism; leadership, support, and technical assistance for two parent/family support groups for fatty acid oxidation disorders and for congenital adrenal hyperplasia and associated disorders.

Title V-CSHCN staff also collaborated with seven states in the Region 4 Genetics Collaborative (IL, KY, MI, MN, IN, OH, WI), identified data elements needed to monitor long-term outcomes for individuals with congenital adrenal hyperplasia based on the template for medium chain acyl-CoA dehydrogenase deficiency (MCADD). Minnesota infant and young children with metabolic disorders and congenital adrenal hyperplasia were enrolled in an online emergency care medical services information system (MCHB funded MEMSCIS). Approximately 70 families are participating in this ongoing activity.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide newborn testing as recommended by the State Newborn Screening Advisory Committee.	X			
2. Expand follow-up activities to identified infants & their families for all NBS tests.	X	X	X	X
3. Refine lab procedures for reducing false positive/negative test results.	X	X	X	
4. Expand educational materials & activities to include all disorders identified by NBS bloodspot and early hearing detection and intervention	X	X		

5. Refine integrating data collection, infant follow-up & tracking, and program outreach with hearing screening program	X	X	X	X
6. Link identified infants & their families to community resources & a medical home	X	X		X
7. Support primary care providers, comprehensive centers and systems that care for infants and children with rare disorders.	X			X
8. Continue active participation on the Newborn Screening Advisory Committee.				X
9. Implement linking blood spot and hearing data with birth/death certificates			X	X
10. Develop and implement an evaluation plan for program initiatives.				X

b. Current Activities

Ongoing planning, implementation and evaluation to determine long-term outcomes are extensive. To date, data elements for nineteen conditions have been developed including a disorder from each of the three major categories: amino acidemia, organic acidemias and fatty acid oxidation disorders. Conditions over time are being added to a secure, web based platform, DocSite. Minnesota is implementing data for MCADD and those disorders currently entered in the platform.

Minnesota staff began assessing means to track infants with endocrine, hemoglobinopathies, metabolic, pulmonary and hearing disorders found through newborn screening. Collaborations with partners and systems are integral to this activity. Some statewide partners include primary care providers (Medical Home) population-based programs such as MCSHN, Universal Hearing Screening Program, high risk follow-up programs, local public health, early education and families.

The major departmental policy issue during the current year was the department's proposed response to legal issues raised on the function of storing blood spots. Proposed legislation, supported by the Governor's Office, that would have limited the storage of blood spot cards to two years was not adopted by the Legislature. Concomitantly, a lawsuit was filed against the department for storing blood spot card of infants born in the past two years. A court will hear the lawsuit in July.

c. Plan for the Coming Year

Staff will continue collaboration with partners to more effectively improve the needs of systems serving this population as well as providing information to families about a variety of services for infants diagnosed with a condition found through newborn screening.

Collaboration, technical assistance and evaluation of needs of children with cystic fibrosis are a new focus now that Minnesota began screening for this disorder a few years ago. Minnesota has two nationally accredited centers and one seeking accreditation.

The Title V program will continue to support parent organizations, especially two new family groups (FAOD and CAH). Region 4 activities will support many aspects of collaboration with medical home providers and the state will remain an active participant in the seven work groups and the two competitive HRSA grants awarded to Region 4. The Public Health Lab is redesigning its management information systems and the Title V program is working with the labs to ensure the tracking needs for long term follow-up are included where appropriate in that revision. The Labs continue to add tests for additional conditions and follow up actions will have to accompany those additional tests.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	59.1	63	63	63	63
Annual Indicator	59.1	59.1	60.3	60.3	60.3
Numerator	90893	90109	103284	103284	103284
Denominator	153795	152468	171251	171251	171251
Data Source					National Survey of CSHCN 05/06
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	63	63	65	65	65

Notes - 2008
Data source is the National Survey of CSHCN 2005/ 06

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

2007 data not yet available.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
The MDH/MCSHN funded Parent Leadership Summit was held in April of 2008. It focused on Cultural and Linguistic Competency and included a presenter from the National Center for Cultural Competency discussing the role of cultural competency in the parent leadership movement. The role of parents in the pediatric medical home learning collaborative continued to grow. Lessons learned from parent participation in medical home are guiding parent participation in the EDHI learning collaborative, which held its first learning session in September of 2008. When the Medical Home Collaborative began 4 years ago the role of parents participating on quality improvement teams was a relatively new concept for many providers and parents. Parent partners have now become parent leaders and have taken on significant roles as faculty for the Minnesota Medical Home Collaborative. Medical Home parent partners consistently present during new team orientation on the role of family-centered care in Medical Home and the role of parent partners on the teams.

MCSHN district staff held 44 "Taking the Maze Out of Funding" workshops with a total of 957 attendees including parents of children with special health care needs, local public health, education and human service providers and numerous private health and related services providers. The tools developed to determine which financial resources a child may be eligible for are particularly useful according to participant evaluations. MCSHN staff continued support and participation in the Parents as Teachers program -- part of the University of Minnesota's Pediatric Residency rotation in developmental disabilities; as well as support for Family Voices

Over the past year through collaboration with the Healthy and Ready to Work National Center, a youth network has been developed in coordination with Medical Home Improvement teams. This youth network developed a tip sheet for physicians and families in the Medical Home Learning Collaborative that was distributed at the April 2008 Medical Home Learning Session. In addition, the members of this youth network presented a breakout session at the April Medical Home Learning Session.

At the April 2008 Medical Home Learning Session representatives from Partners in Policy Making, a program of the Governor's Council on Developmental Disabilities presented a breakout session that included information about the history of disabilities in Minnesota and how family and consumer leadership in policy has improved the lives of individuals in our state.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Update MAZE training materials to reflect legislative, policy and procedural changes to programs.				X
2. Continue to target parents as a MAZE audience	X		X	X
3. Support medical home teams and their parent-members through Title V resources		X		
4. Apply lessons learned about family involvement from medical home collaborative activities to the Development and Behavior Clinics	X			X
5. Provide financial recognition of parent time on medical home and other activities pursuant to the New Freedom Initiative grant		X		
6. Revise (as necessary) fact sheets for parents on genetic conditions of infants identified through the state's birth defects information system			X	X
7. Support outreach activities of the MnSIC process to parents on Interagency Coordinating Committee				X
8. Continue leadership in the Part C program and support of parents on both the ICC and the IEICs		X		X
9. Support establishment of a strong Family Voices network in the state				X
10. Establish and support regional networks of parent leaders				X

b. Current Activities

The work by the parents as partners in the medical home collaborative had a definite impact on implementation of health care homes. A consumer-family council was formed to advise the health department on all areas of health care home implementation. This group has been meeting every other month as rules have been proposed.

Another major activity involving families during this time frame involved autism and the Somali community. There are high rates of participation of Somali children in early childhood special

education programs in Minneapolis. This raised concern among Somali parents and educators that there was a higher rate of autism in the Somali community. In response, the Title V program directed epidemiological resources to analyze the Minneapolis data, resulting in the report "Autism Spectrum Disorders among Preschool Children Participating in the Minneapolis Public Schools Early Childhood Special Education Programs". Title V also sponsored a one-day forum for parents, providers and educators: "Autism in Somali Children: Building Partnerships to Improve Care". Both of the above activities on autism included the connections between services and satisfaction with those services.

c. Plan for the Coming Year

The CYSHCN Title V program in Minnesota will continue and increase its role as a leader in the state of Minnesota in promoting parent/family/youth partnership and leadership in program and policy planning, implementation and evaluation. In addition, the CYSHCN program intends to take a leadership role in promoting and enhancing family-centered care throughout Minnesota through partnership with providers, hospital systems, policy makers and other state programs.

Minnesota's CYSHCN program will continue to take a leadership role in supporting the agreement between AMCHP and Family Voices National and therefore will enhance its role in supporting Family Voices of Minnesota.

At the policy level, the CYSHCN program will continue to advocate for parents in leadership bodies within Title V and related activities such as the Newborn Hearing Screening Committee, the Minnesota State Interagency Committee (MNSIC), and the Maternal and Child Health Advisory Task Force.

At the practice level, parents as quality improvement partners is viewed as absolutely essential. The Somali community has a very high interest about Autism and Title V intends to follow up with more epidemiological work and with a quality improvement learning collaborative on autism and other developmental disabilities. Parent satisfaction with services will be a key component of the collaborative.

At the individual level, the monograph "Working With Doctors" will continue to be available to families who are looking to become partners with their child's physician. The toll free information and assistance lines will continue to serve as a resource for parents, who sometimes struggle with the physician/parent relationship, by providing resources and ideas for varying approaches to enhance communication.

Health Care Home will begin a critical year of implementation. The Consumer-Family Council formed to advise the commissioner will play an important role in maintaining patient engagement as a vital element in family-centered and patient-centered care and the Title V program will assist that council whenever possible.

The Title V program has begun its planning for the five year needs assessment and will involve families in the process of determining the final ten priorities.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008

Annual Performance Objective	48.7	53.6	53.6	53.6	54
Annual Indicator	48.7	48.7	51.8	51.8	51.8
Numerator	74898	74252	88280	88280	88280
Denominator	153795	152468	170372	170372	170372
Data Source					National Survey of CSHCN 05/06
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	54	54	54	54	54

Notes - 2008
data source: National Survey of CSHCN 2005/06

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
Minnesota has organized, funded and conducted a pediatric Medical Home Learning Collaborative since 2004. Twenty-four private clinic teams participated in three medical home learning sessions during federal fiscal year 2008. Sessions were conducted in January of 2008, and in April and September of that year. The September session was unique in that it combined the thirteenth medical home learning session with the first learning session for the Early Hearing Detection and Intervention collaborative. The latter collaborative is part of the state's approach on the policy and program issue of loss to follow-up to early intervention of those infants with a diagnostically confirmed hearing loss.

The January 2008 learning session focused on the chronic care model and medical home, the Medical Home Index, electronic medical record systems, IEPs and involvement of clinic administration with medical home activities. The April session focused on planned care visits, billing strategies, transition, parent training programs conducted by the state's Council on Developmental Disabilities and web resources. In the September session, the medical home teams focused on Patient and Family-Centered Care (Jeanne McAllister, Center for Medical Home Improvement, was the featured speaker), transition issues and unique characteristics of medical home in Minnesota. The EHDI teams focused on the Model for Improvement, care coordination, early identification and quality intervention for children with hearing loss and developmental outcomes for those children.

The major event occurring in this period was the passage of health care reform legislation by the

2008 Legislature. Minnesota had already enacted legislation in 2007 that prompted the state to begin policy planning for care coordination services provided to fee-for-service Medicaid enrollees. In 2008 the state enacted legislation extending the requirement to provide (and pay for) patient-centered medical homes to all payers regulated by state government. This resulted in the concept of health care homes being extended to all Medicaid, MinnesotaCare and SCHIP beneficiaries, state employees and fully (non-ERISA) insured in Minnesota.

The 2008 legislation required the health commissioner certify practices as a health care home through a voluntary process beginning in July of 2009. Consequently, standards had to be developed for certification. This process began in the fall of 2008 with the formation of a community-wide certification work group. The group was comprised of consumers, primary care providers, other providers, insurers, local public health and other community-based providers. Standards for certification are to be implemented beginning in July of 2009 and care coordination payment to certified practices is to begin by July 2010.

At the same time, the department also drafted a number of RFPs to examine the capacity of the primary care system to implement health care homes. Title V staff were instrumental in drafting these RFPs. Most notable was the identification of outcomes to be used in evaluation of health care homes ("Recommendations of Health Care System and Patient Outcomes to Consider in the Evaluation of Health Care Homes", prepared by the Institute for Clinical Systems Improvement, www.icsi.org)

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Use "learnng collaborative" approach to expand the number of children receiving coordinated care.		X		
2. Continue to partner with the state chapter of the AAP				X
3. Continue efforts to assure identified reimbursement stratgies for medical home come to fruition				X
4. Continue efforts at integration of mental health services with medical home activties.	X		X	X
5. Promote concept of medical home through education of local public health personnel				X
6. Pursue curricula development about medical home with appropriate university programs				X
7. Work with state medical association, as it promotes medical home				X
8.				
9.				
10.				

b. Current Activities

The current federal fiscal year has been one of transition for pediatric medical home as the state continues to prepare for certification of primary care practices as health care homes. The pediatric collaborative hosted two learning sessions. The January 2009 session focused on patient and family-centered care and the May session focused on transition from medical home to health care home.

Implementation of health care homes became a departmental priority and its activities were located in the Executive Office of the Minnesota Department of Health. RFPs continue to be drafted and published with the assistance of Title V staff. RFPs included one on assessing the capacity of the primary care system in the state to implement health care homes and one on

evaluating collaborative learning models. Final reports from both activities are to be completed by the end of June. The Certification Work Group continued to meet during this time frame and made recommendations on a set of proposed rules for certification of practices as health care homes. These recommendations were reviewed internally and proposed rules for certification are anticipated to be adopted in late July or early August.

Staff continued to work with external stakeholders to educate and promote the concept of medical home, including University of Minnesota graduate and professional programs in the School of Public Health and School of Nursing and the Medical School.

c. Plan for the Coming Year

The Title V-CSHCN program (MCSHN) will pursue five broad strategies to promote medical home. First, it will work with its colleagues in the health care home unit to promote certification of primary care practices as health care homes. MCSHN district staff located throughout the state will play a pivotal role here because of their knowledge of the public and private sector health system within their respective districts. Secondly, MCSHN will continue to work with the state chapter of the AAP, the Center for CSHCN at the University, the School of Public Health, Family Voices and other major institutional stakeholders to inform and educate students, parents, providers and decision-makers about medical home.

MCSHN will also continue to work with its MDH colleagues in the Public Health Lab (newborn screening) and in Environmental Health (Birth Defects Information System) to continue and improve those systems and to link families of infants diagnosed/identified through those systems with a medical home.

Fourth, MCSHN has applied for an autism intervention research grant from the Bureau. The proposal is focused on a quality improvement approach not a medical home perspective, although successful implementation would include medical home principles. State funds have been allocated to begin this activity regardless of federal funding decisions, but there is only enough state funding for one year. The fifth broad strategy involves the Early Hearing Detection and Intervention (EHDI) program. A learning collaborative is being used to promote quality improvement efforts among regional EHDI teams to reduce the number of infants with a confirmed permanent hearing loss lost to follow-up through failure to be enrolled in early intervention services. Included in the collaborative sessions are the success stories in medical home and efforts to link infants diagnosed with a permanent hearing loss to a medical home.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	68.8	70	70	70	66
Annual Indicator	68.8	68.8	66.3	66.3	66.3
Numerator	105795	104898	116294	116294	116294
Denominator	153795	152468	175428	175428	175428
Data Source					National Survey of CSHCN 05/06

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	66.3	66.3	70	70	70

Notes - 2008
Data source: National Survey of CSHCN 2005 / 06

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
Although not one of the final 10 priorities ultimately adopted in the 2005 Title V Needs Assessment process, insurance coverage was one of the top 15 priorities in each of the three population groups (CYSHCN, Women and Infants, and Children and Adolescents) analyzed in that process. Minnesota has always been a leader in insurance coverage of its children. State-specific studies over the last ten years indicate 93-95 percent of children in this state have had health insurance during that time and that the majority of those without coverage are eligible for either Medicaid or MinnesotaCare. Data from 2006 indicate 67.5 percent of the state's population are privately insured (both fully-and self-insured) and 25.1 percent are insured through programs such as Medicare, Medicaid and MinnesotaCare. Latest available data (2007 Minnesota health Access Survey)) indicate 94 percent of children and youth under 17 have insurance. However, 19 percent of youth between 18 to 24 were uninsured. The overall uninsured rate for the state is 7.2 percent.

The issue of the adequacy of insurance for children in general, and CYSHCN in particular, has never been as rigorously addressed as the question of whether children have any type of health insurance. The only studies analyzing adequacy of insurance are the National Survey of Children with Special Health Care Needs conducted in 2001 and 2005. The 2001 study indicated that 68.8 percent of Minnesota's children with special health care needs had adequate insurance at the time of the survey and the 2005 study indicated 70 percent had adequate insurance.

One area of continuing activity by the CYSHCN program is that its staff are instrumental in educating families and community professionals about eligibility and coverage criteria of publicly funded, health insurance programs. This activity, called MAZE trainings ("Who Pays? Taking the Maze out of Funding"), provided training to 950 people through 44 different training sessions during the report year.

As a result of a federal audit of IDEA funds, the state had to expand the enrollment in its Part C program beginning July of 2007. Title V-CSHCN staff were instrumental in developing protocols for eligibility determination for participating in Part C and that program doubled in size by July of 2008.

Staff also work closely with the Children's Mental Health Services division of the Minnesota Department of Human Services by supporting training sessions on the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood™ (DC:0-3™). This is a classification system developed by the Zero to Three organization and is based on the recognition that young children can experience social-emotional and developmental disorders and that a system for diagnostic classification sensitive to the developmental issues of young children was needed. It can also be used as a basis for third-party reimbursement since DC: 0-3™ codes can be converted to DSM-IV codes.

Lastly, MCSHN staff worked closely with department of human services colleagues in the development of a universal assessment protocol to ensure greater consistency across the state for determining eligibility for publicly-funded programs for all populations with disabilities under the age of 65.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Analyze 2009 legislative changes in publicly-funded, state health insurance and waiver programs.				X
2. Update MAZE materials to reflect legislative policy or procedural changes to programs.				X
3. Promote and conduct MAZE trainings statewide.		X		X
4. Integrate MAZE trainings as a resource into medical home activities.		X		X
5. Continue support of Children's Mental health Services initiatives and DC:0-3 Trainings.	X		X	X
6. Maintain and enhance staff knowledge base about insurance, issues and implications.				X
7.				
8.				
9.				
10.				

b. Current Activities

Five activities have been directed to the issue of adequacy of insurance during the current federal fiscal year. Parents and professionals continued to attend MAZE trainings. Collaboration with Children's Mental Health Services of the Minnesota Department of Human Services (DHS) in sponsoring to DC: 0-3™ trainings continued throughout the state.

The CYSHCN program continues to partner with the hospice and palliative care program of a local children's hospital to support its efforts to restructure Medicaid reimbursement for children's hospice/palliative care. Effective January 1, 2009, the state received approval from CMS for payment to Provider-Directed Care Coordination activity. These are payments for physician services on behalf of fee-for-service Medicaid patients. This initiative is a result, in part, of the Title V medical home initiative. Staff continue to work with Health Economics staff of the department on using results from the biennial health access survey, which is the state's primary data source for defining and resolving policy issues surrounding health insurance.

c. Plan for the Coming Year

MAZE and DC: 0-3™ trainings will continue. MCSHN will continue to support the effort to restructure hospice and palliative care reimbursement for children. Given the on-going and multi-

faceted efforts to segment health insurance coverage, it is incumbent upon MCSHN to develop an expertise on insurance products such as Health Savings Accounts, Health Reimbursement Accounts and other forms of consumer directed health care products in order to provide timely and accurate information to families of CYSHCN on these issues. Finally, Minnesota is embarking on significant efforts at health care reform and MCSHN needs to ensure that linkages between those efforts and the Title V-CSHCN program exist to ensure interests of CSHCN and their families are represented.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	73.5	78.5	78.5	78.5	91
Annual Indicator	73.5	73.5	90.7	90.7	90.7
Numerator	113039	112064	160677	160677	160677
Denominator	153795	152468	177112	177112	177112
Data Source					National Survey of CSHCN 05/06
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	91	91	94	95	95

Notes - 2008
Data Source: National Survey of CSHCN 2005 / 06

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
In 1998 Minnesota enacted legislation known as the Interagency Services for Children with Disabilities Act. Now referred to as the Minnesota System of Interagency Coordination (MnSIC) by its state and local partners, has as its purpose the "…development and implementation of a coordinated, multidisciplinary, interagency intervention service system for children In 1998 Minnesota enacted legislation known as the Interagency Services for Children with ages birth

through 21 with disabilities." This legislation affects all agencies and educational organizations working with these individuals and their families. A state appointed committee -- the State Interagency Committee (SIC) -- has been appointed to oversee implementation of this initiative at the state level. The CYSHCN director is a member of this policy-making body.

The governing boards of the 95 local Interagency Early Intervention Committees (IEICs) located throughout the state are designated with the responsibility of designing and implementing their birth through 21 interagency systems. The goal of this endeavor is to increase the level of coordination of services for the individual child and his or her family.

The Minnesota Department of Education is the lead state agency for the implementation of the Part C program of IDEA. The federal Office of Special Education Policy conducts audits of state Part C programs and its 2005 audit of the Minnesota program found the state out of compliance with federal eligibility guidelines for Part C programs. The net result of the audit is that Minnesota had to revise eligibility criteria for enrollment of infants and toddlers in the program. MCSHN personnel were key state staff in formulating the state position in response to the audit's findings and implementing changes during SFY 2008.

The CYSHCN program has an interagency agreement with the department of education that delegates the child find responsibility pursuant to IDEA to the Title V-CYSHCN program. The Infant Follow Along Program is the means by which this responsibility is implemented. The Follow Along Program is implemented at the local level primarily by local public health agencies. A little more than 30,000 children birth to five were enrolled in the program in federal fiscal year 2008. The program uses the ASQ and ASQ-SE screening tools.

Use of these screening tools has, in part, increased collaboration between the Title V program and the Children's Mental Health Services (CMHS) Division of the Minnesota Department of Human Services (DHS). CMHS was the recipient of a Commonwealth Fund grant (ABCD-II), the goal of which is to integrate mental health services into the primary care practitioner setting. Part of the objectives designed to meet this goal have included provider training in the ASQ and ASQ-SE screening tools, as well as trainings in the Diagnostic Classification 0-3 (DC:0-3™) system. The purpose of these trainings is to facilitate young children with diagnosable conditions accessing mental health services under the state's Medicaid system.

MCSHN staff conduct trainings called "Who Pays? Taking the Maze out of Funding" targeted to parents, professionals and advocates. Approximately 950 individuals attended these trainings during the report year. The content of the trainings provides up-to-date information about eligibility and coverage on the state's Medicaid program, the MinnesotaCare program and the state's home- and community-based waiver programs.

The Environmental Health Division of MDH is a recipient of a CDC grant to develop and implement a birth defects surveillance system. MCSHN has assisted this unit through serving as a resource for the families of infants identified with a birth defect, development of fact sheets for each of 44 different birth defects and working with local public health agencies for those agencies electing to be the first public health point of contact for families.

Implementation of the birth defects surveillance system has been successful. Complete implementation occurred during state fiscal year 2008. The MCSHN program was the original point of contact with families for the purpose of linking families with resources. During the report year discussions have taken place with local public health agencies of some of the more populous counties for those agencies to assume that function; some have chosen to do so and some not.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to partner with other state agencies to fully implement the interagency coordination process				X
2. Create an updated, searchable, web-based central directory for Part C		X		
3. Continue state support and technical assistance for the Infant Follow Along Program			X	X
4. Inform and educate providers, community professionals and parents about the ASQ-SE mental health screening component of the Ages and Stages Questionnaire			X	X
5. Continue active participation and leadership in statewide ICC, IEIC and Part C activities				X
6. Continue support of DC: 0-3 trainings			X	X
7. Support activities on autism			X	X
8. Provide staff development to enhance their expertise for technical consultation in above mentioned programs	X		X	X
9. Continue support of the birth defects surveillance system at the state level and support of local public health at the community level	X		X	X
10. Partner with department of education in implementing revised state rule for Part C eligibility	X		X	X

b. Current Activities

The MnSIC activity described above is on going. Implementation of the concept of interagency coordination of services for disabled children has met with modest success. Local concerns, especially within the educational system, center on unfunded mandates and payer of last resort for mental health services. Much of the current year has been spent on revising training materials, as well as analysis of the strategies and tactics of four different counties that have been successful in implementing interagency coordination within their respective jurisdictions.

Several activities occurred within the EHDI portfolio with a focus on improving systems and services. A statewide EHDI learning collaborative and participation in a national EHDI collaborative have helped identify points in the screening-diagnosis-intervention continuum that need improvement to assure the earliest possible intervention and reduce loss to follow-up.

Another major activity involving families during this period involved autism and the Somali community. There are high rates of participation of Somali children in early childhood special education programs in Minneapolis, raising concerns in the Somali community about the rate of autism. Title V sponsored a one-day forum for parents, providers and educators: "Autism in Somali Children: Building Partnerships to Improve Care" to begin to address these concerns.

c. Plan for the Coming Year

The Title V-CYSHCN program continues its support of the MnSIC concept and activity because Title V believes there are many parallels between medical home and the MnSIC goal of interagency coordination including coordination of services, family-centered care and an increased role for parents in the decision-making process. The primary strategy for communication over the next few years to ensure community-based service systems are organized for ease of use by families rests with utilizing the infrastructure of the 95 local Interagency Early Intervention Committees (IEICs) throughout the state.

The CYSHCN program will continue to collaborate with Children's Mental Health Services

through co-sponsorship of the DC:0-3™ training sessions and will continue Implementation of quality improvement activities. Materials for the "Who Pays?" trainings will be updated and trainings will be provided free of charge to multi-disciplinary audiences.

The birth defects surveillance activity will continue and MCSHN will support that activity in three different ways. First, it will review and update as necessary the fact sheets on each of the 44 different birth defect conditions. Secondly, the Information and Assistance function of the MCSHN program will be used to link families with resources. Lastly, MCSHN will serve as a back up for those local agencies that elect to be the first point of contact to link families with resources.

MCSHN is engaged in a multi-division activity on the topic of integrated child health information systems, the purpose of which is to establish a department-wide, coordinated approach to the analysis, planning and business case development of activities that will enable thoughtful and efficient progress towards creating greater interoperability across child health information systems within MDH. This will continue with special emphasis on further development of a management information system to track long-term follow-up of infants/toddlers/children that have been diagnosed with permanent hearing loss.

Lastly, MCSHN will organize and conduct a collaborative learning session on autism and other developmental disabilities during the coming state fiscal year with one objective being improvement of linkage between families, physician practices and community resources.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	5.8	6.4	6.4	6.4	55
Annual Indicator	5.8	5.8	5.8	52.9	52.9
Numerator	8920	8843		39459	39459
Denominator	153795	152468		74600	74600
Data Source					National Survey of CSHCN 05/06
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	55	57	57	59	59

Notes - 2008
Data Source: National Survey of CSHCN 2005 / 06

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern

revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
Participation on the State Transition Interagency Committee (STIC) continued. MCSHN district staff are active in local Community Transition Interagency Committees (CTICs) and work with local public health agencies to keep them informed of proceedings and events. District staff communicate this information at local maternal child health meetings to help local public health nurses better understand the impact of health on transition. District staff presented information to school nurses on the impact that health, education and human services can have on transition outcomes. Transition information continues to be distributed at MCSHN's Development and Behavior Clinics when the age of the patient is appropriate. Adolescents are taught how to advocate for themselves and self care, social skills and transition to adult health among other interventions are discussed.

MCSHN co-sponsored a conference on transition with the Center for CSHCN at the University of Minnesota School of Nursing (a Title V DRTE grantee). Held in January of 2008, it was entitled "Building an Interdisciplinary Research Agenda to Enhance Quality of Life and Transition to Adulthood for Youth with Chronic Health Conditions". It was a working conference that brought together health professionals, educators, policymakers, human service providers and young adults to focus on transition issues facing adolescents with chronic conditions. Through MCSHN's financial support, the Center was able to invite Dr. Judith Palfrey of the Harvard School of Public Health and Professor Richard Roberts of the Early Intervention Research institute at Utah State University as the two conference speakers. Conference proceedings were published in April of 2008 both in hard copy and on DVD.

The co-director of the Healthy and Ready To Work National Center serves on the Medical Home Collaborative Leadership Advisory Committee. In April of 2008 Healthy and Ready to Work provided a breakout session at the Medical Home Collaborative on transition in order to engage individual health care practitioners in improving transition services for CYSHCN. A number of Medical Home teams are engaged in improving transitions. Youth focus groups, having youth members of the quality improvement team and developing materials are among their activities.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue involvement with MnSIC and interagency coordination activities				X
2. Continue to incorporate transition into health care home activities				X
3. Include transition expertise on medical home/health care home leadership group				X
4. Continue involvement with the State Council on Disability				X
5. Provide analysis of the MN Student Survey relevant to youth with special health care needs				X
6. Continue involvement with the CTIC			X	X
7. Provide transition services for adolescents seen in the DBCs	X			

8. Provide information and assistance to individual callers seeking advice on transition planning	X			
9. Promote transition as a topic to be addressed by state professional medical organizations			X	X
10. Continue involvement with the North Dakota transition collaborative				X

b. Current Activities

The Taking the Maze out of Funding transition packet is updated annually and distributed throughout the state as part of Maze presentations. District staff offers technical assistance to local service providers, parents and youth on transition issues. A Youth Network developed information on transition issues for the MCSHN website. These young men and women, facilitated by the Co-Director of Healthy and Ready to Work, then presented this information at the May, 2009 medical home learning session, The presentation focused on their recommendations on information helpful to make a successful transition

MnSIC is described in detail in NPM # 5. A MnSIC priority this year has been the transition from special education to community-based services for young adults The Minnesota Department of Education distributed a Transition Toolkit and MCSHN provided information on health and transition and was also be a part of the planning and distribution. The Minnesota CSHCN Director is on the North Dakota Advisory Committee for implementation of its learning collaborative on healthy transitions.

Work has begun by the MDH as a whole on its department-wide response to H1N1 in anticipation of the next flu season. The department is using an emergency response structure in its preparation and MCSHN is represented on the special populations unit. Youth in transition will be a target population for educational material on the need to be vaccinated.

c. Plan for the Coming Year

District staff will continue involvement in CTICs, Medical Home/Health Care Home teams, School Nurse and MCH meetings to address the implications of chronic disease and disability on youth with special health needs. MCSHN staff will serve on the state level transition advisory group.

There will be an emphasis on H1N1 planning. Influenza vaccination is recommended for children and adolescents. Those young men and women who are in a transition mode with their health care may need to be a specific target population for education on the need to be vaccinated.

The triennial Minnesota Student Survey will be conducted in the spring of 2010. Analysis and dissemination of the survey relative to students with special health care needs will be priority area for MCSHN. A great deal of effort and discussion regarding the question of identifying students with special health care needs resulted in dividing the original question "Do you have a physical or mental health condition that has lasted more than a year?" into two questions to allow analysis by physial condition or mental health condition. Previous surveys have demonstrated substantial disparities between youth with special health care needs and their peers, particularly in the areas of vicitimization (both at home and at school) and symptoms of depression.

The coordinator of the Healthy and Ready to Work National Center will continue to collaborate with MCSHN and facilitate youth leadership activities. There will continue to be collaboration with colleagues in North Dakota as it implements its New Freedom Initiative state implementation grant focused on transition to work and independence for youth with special health care needs.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	90	90	90	90	85
Annual Indicator	85.2	82.5	82.6	93.1	
Numerator	56015	55417	58242	65174	
Denominator	65745	67173	70511	70004	
Data Source					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	85	86	87	87	87

Notes - 2008
2008 data not yet available.

Notes - 2007
2007 data not yet available

Notes - 2006
2006 data are not yet available.

a. Last Year's Accomplishments
Although Minnesota's statewide immunization rate is consistently above the national average, there are pockets of under-immunized children in some high risk populations. In Minnesota the Title V program is not the lead entity for immunization activities. The immunization program is managed by the Infectious Disease Epidemiology, Prevention and Control Division. Title V staff collaborate with the immunization program by supporting and providing outreach and information, and providing immunization information to providers through Child and Teen Checkups (C&TC) trainings.

Minnesota continues work on Integrating Child Health Information Systems (ICHIS) involving immunization registry, vital records, newborn dried blood spot screening, newborn hearing screening, Birth Defects Information System, WIC, CYSHCN, blood lead program, and legal and system technology staff. MDH is still addressing issues around developing a unique child identifier. Immunization registry staff remain actively involved by offering input on their process for unique child identifiers. They have supported "pilot" attempts for ICHIS, using the immunization registry system to test possibilities of data matching across child health program areas. This work will continue over the next several years as Minnesota works to meet its statewide e-Health goals.

Minnesota's immunization registry, the Minnesota Immunization Information Connection (MIIC) is a statewide network of seven regional immunization registries and services involving health care providers, public health agencies, health plans, and schools working together to prevent disease and improve immunization levels. These regional services use a confidential, computerized information system that contains shared immunization records. MIIC provides clinics, schools,

and parents with secure, accurate, and up-to-date immunization data. MIIC users can generate reminder cards when shots are coming due or are past due and can use the system to greatly simplify the work of schools in enforcing the school immunization law. In Minnesota, all parents of newborns are notified of their enrollment in MIIC through Minnesota's birth record process. An immunization information packet given to all new parents in the hospital. They are given a toll-free number to call with questions or if they do not want to participate. Very few individuals decline each month, mostly due to general objection to immunizations.

Regional immunization information systems are supported by the MDH through technical, policy, and financial assistance, as well as hosting the web-based application and managing its security. The MIIC is increasing its saturation level and currently has a saturation level of 80% or more for 83 out of 87 counties for children ages 0-6 years of age with two or more shots entered into MIIC.

The Eliminating Health Disparities Initiative (EHDI), established in the 2001 legislative session to close the gap in the health status of Africans/African Americans, American Indians, Asians, and Hispanic/Latinos in Minnesota compared with Whites, supports grants to communities. One of the priority areas is increasing immunization rates. Eight of the grantees have chosen increasing immunizations as one of their goals. Activities this past year included conducting immunization clinics, awareness campaigns and education workshops, and assisting individuals with accessing health care and referral services. Anecdotal information indicates increased immunizations by school entry and increased knowledge of the importance of immunizations among people of color and American Indians.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Target information on immunizations to high-risk populations			X	X
2. Provide immunization training sessions to public and private providers through C&TC/EPSDT training			X	X
3. Immunization review as part of WIC clinic services			X	X
4. Support local community immunization registries			X	X
5. Support MIIC strategic plan with emphasis on recommendations for integrating information with other child health data systems.				X
6. Support local immunization clinics	X			
7. Support inoperability of data across various data sets. (Medicaid, WIC, Birth Certificates, Immunization Registry, BDIS, etc.)			X	X
8. Continue to work with the Office of Minority and Multicultural Health on improving immunization rates for racial and ethnic populations			X	X
9.				
10.				

b. Current Activities

Title V continues to provide information and training about immunizations, immunization requirements, access, availability, and other immunization related information to child care, home visiting and C&TC providers, and other local public health MCH staff. Information is also able to be downloaded from the MDH web site. The immunization program, WIC, and C&TC providers continue to collaborate to link immunization information in the various systems to improve vaccination coverage.

MDH provides support for increasing immunization rates in a variety of ways. The MDH provides

educational materials in English and other languages, provides educational opportunities for immunization providers around the state. In October 2008, MDH supported a television program educating the public on immunizations in English and seven other languages through a partnership with the ECHO (Emergency and Community Health Outreach) Program.

The Immunization Practices Improvement (IPI) program uses MIIC data in working with medical and other immunization providers. The focus of IPI program is on provider quality assurance. An IPI assessment is now required of all providers. IPI hosts monthly conference calls with local public health agencies. In 2007, there were 377 IPI site visits conducted, 50 by MDH staff.

MIIC saturation levels will continue to be tracked and increased participation in MIIC encouraged.

c. Plan for the Coming Year
Title V activities will continue as in the current year. In addition, immunization activities are supported and promoted through state and local family home visiting programs, C&TC and early intervention programs. The Title V program will continue to work with Eliminating Health Disparities Initiative grantees to address health disparities related to immunizations.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	13.5	13	13	12	13
Annual Indicator	13.6	12.5	13.8	13.9	
Numerator	1478	1365	1533	1519	
Denominator	108688	109134	110819	109548	
Data Source					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	12.5	12	11.5	11	11

Notes - 2008
2008 data not available yet.

Notes - 2007
2007 data not yet available

Notes - 2006
2006 data are not yet available.

a. Last Year's Accomplishments
The MDH used $10.78 million in state and federal funds over two years beginning July 1, 2007 to support the Family Planning Special Projects (FPSP) grant program. These funds are distributed through grants to local health departments (LHDs), tribal governments and non-profit organizations to support family planning services (outreach, public information, counseling and

method services).

Thirty-five percent of the funds support family planning services for teens. From July 2007 through June 2008, over 23,000 men and women received contraceptive methods from the 40 FPSP grantees. Thirty-five percent of females served were from populations of color and American Indians. MDH provided technical assistance to LHD to address teen pregnancy in their communities.

State funds support a family planning and STI hotline staffed by individuals trained in information, referral, family planning and STI counseling. Over 2,800 calls were handled by the hotline from July 2007 through June 30, 2008. Information on the hotline is mailed annually to Medicaid and Minnesota Care recipients.

The Adolescent Health Coordinator provided technical assistance to the Minnesota Organization on Adolescent Pregnancy Prevention and Parenting (MOAPPP) for their annual conference. Additionally, the coordinator was on faculty for the University of Minnesota's 2008 Summer Institute in Adolescent Health which covered sexual health and best practices related to teen pregnancy prevention. The coordinator distributed teen pregnancy prevention best practices and funding opportunities to over 700 LHDs, community based organizations through the monthly Adolescent Health E-Newsletter. The coordinator received funding for Adolescent Pregnancy Prevention through Association of Maternal and Child Health Programs (AMCHP) and National Association of City & County Health Officials (NACCHO). This funding established a partnership between MDH, a LHD and a suburban community based organization to address the high rates of teen pregnancy and STIs in Richfield, MN. A town hall meeting was planned to mobilize the community and garner more support for the issue in Richfield. The coordinator provided presentations and one-on-one technical assistance to LHDs doing family home visiting to increase the capacity to address adolescent pregnancy prevention/youth development related activities.

Funding for the MN Education Now and Babies Later (MN ENABL) program ended in 2008. The remaining state dollars were granted to MOAPPP to support their Teen Outreach Program (TOP) and to provide further training and technical assistance on service learning and teen pregnancy prevention.

The Medicaid 1115 Waiver program, Minnesota Family Planning Program (MFPP) completed its second year. It continues to serve around 28,000 individuals per year. Under MFPP, adolescents (15 years of age and above) are eligible for family planning services.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide access to Family Planning Special Projects services	X	X	X	
2. Partner with DHS to successfully implement 1115 Waiver for family planning services			X	X
3. Increase public understanding of social, economic, and public health burdens of unintended pregnancy, especially to teens			X	X
4. Develop public understanding and support for policies and programs that reduce unintended pregnancies			X	X
5. Promote youth activities that support resiliency and healthy behaviors	X		X	X
6. Support hotline for family planning and STI services	X			X
7. Support school-based clinics and advocate for comprehensive sexuality education	X		X	X
8.				

9.				
10.				

b. Current Activities
Forty FPSP grantees continued to receive money in the second year of the grant cycle that ends June 30, 2009. Staff conducted site visits with all grantees. A RFP for the next grant cycle (beginning July 1, 2009) was released January 2009. Forty-nine applicants requested $5.6 million more than available funding. MDH promotes the 1115 Medicaid Waiver and assist FPSP grantees in implementation of the waiver.

The Adolescent Health Coordinator provides technical assistance to MOAPPP on their annual conference. The coordinator distributes teen pregnancy prevention best practices and funding opportunities to LHDs and CBO's through an e-newsletter. Staff recently received funding for an additional Adolescent Pregnancy Prevention grant through AMCHP and NAACHO to work in Worthington, MN. This funding will establish a partnership between the MDH, Department of Education, MOAPPP, and a LHD to address the high rates of teen pregnancy. In March 2009, the Coordinator became a certified trainer in the Teen Outreach Program (TOP) through Wyman Center. Staff continues to provide one-on-one technical assistance to LHDs doing family home visiting to increase the capacity to address adolescent pregnancy prevention/youth development related activities.

Staff and American Indian community members are exploring evidence based approaches for working with the American Indian population around teen pregnancy prevention as a result of findings from an American Indian Infant Mortality Review Project.

c. Plan for the Coming Year
Continued coordination, collaboration and advocacy will be necessary to preserve and continue work on prevention of unintended pregnancy. Minnesota has a strong history of building on existing partnerships and shared resources to reduce teen pregnancy. MDH staff will continue to facilitate communication and collaboration with community partners on teen pregnancy prevention through a variety of vehicles. The Adolescent Health E-Newsletter provides research, resources, funding opportunities and conferences on many topics related to adolescent health, including teen pregnancy prevention. Partnering with MOAPPP and Wyman Center on TOP replication issues, training, and service learning will also be a part of this coming year's activities. Rates of teen pregnancy and teen births will continue to be monitored and information disseminated on the most up to date information to LHDs and professionals statewide. The adolescent health coordinator will be on the planning committee for the MOAPPP yearly conference on teen pregnancy prevention. The MDH Center for Health Statistics, Minnesota Department of Human Services and the MCH section are currently in the planning stages of developing an adolescent pregnancy and birth data report.

The FPSP Coordinator will continue to provide a monthly newsletter to grantees and will conduct site visits with current and future grantees. Technical assistance will be provided to counties on an as needed basis. FPSP grant awards will begin July 1, 2009. Staff will continue to help promote the 1115 Medicaid waiver and support family planning service providers use of the waiver. FPSP grantees, in partnership with MDH, will provide critical direct services to Minnesota adolescents in an effort to reduce teen pregnancy and teen birth rates.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008

Annual Performance Objective	17	18	14	14.5	14
Annual Indicator	12.0	13.4	12.8	14.2	
Numerator	14794	16420	16069	17235	
Denominator	122956	122626	125178	120950	
Data Source					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	14.5	15	15	16	16

Notes - 2008
2008 data not available from the MN Dept. of Human Services until 3/1/10 .

Notes - 2007
2007 data not yet available

Notes - 2006
2006 data are not yet available.

a. Last Year's Accomplishments
Title V staff participated in several local and state oral/dental health meetings to ensure coordination of activities and more efficient use of MDH resources. The Oral Health Screening Online Training Module was added to the C&TC MDH website in 2007, and was utilized by C&TC providers across the state. It emphasized the importance of oral health screening, discussed common oral health problems and abnormalities, and gave anticipatory guidance advice for providers in regards to oral health and prevention of dental caries.

Title V staff provided education and training resources for C&TC providers on dental screenings, the importance of oral health promotion through age appropriate anticipatory guidance and prevention strategies such as dental sealants and fluoride varnish application and resources. Community collaboratives were created between dentists, oral hygienists, and local health departments (LHD). Community-based services were available through dental schools and oral hygienist programs. Over one-third of the LHDs in Minnesota received instruction and training in fluoride varnish application.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Promote the use of dental sealants and other preventive measures to parents, health professionals and the general public.			X	X
2. Develop strategies that make it easier for children to receive sealants.			X	X
3. Promote and encourage school-based/school-linked sealant programs and appropriate follow-up.			X	X
4. Partner with the DHS to increase utilization of dental services for public program participants.			X	X
5. Incorporate preventive dental practices in the C&TC trainings.			X	X

6. Staff Oral Health State Plan Advisory Group.			X	X
7. Integrate oral health into Medical Home efforts			X	X
8. Work with local public health and other stakeholders on improving children's oral health.			X	X
9. Continue to seek federal or other resources to support oral health promotion activities			X	X
10.				

b. Current Activities

Title V staff collaborated with the Department of Human Services (DHS) to develop and release the "Schedule of Age-Related Dental Standards" for the Medicaid C&TC population in October 2008. The schedule encourages dental exams at 1 year of age and ongoing oral/dental risk assessment. LHD staff are involved in activities to promote oral health, such as a complete oral exam (including 'lift-the-lip' procedure), fluoride varnish application, and oral health promotion with anticipatory guidance for parents and children. According to the 2007 Local Public Health Planning and Performance Measurement Reporting System (LPH PPMRS) data, about half (36 of 75) of Minnesota's LHDs now have oral/dental health programs. Thirty-one LHDs provide some health promotion or educational activities promoting oral/dental health. The remaining eight LHDs do not have any oral/health programs or services.

Staff worked with the Minnesota Dental Association and the DHS on a state Oral Health Summit which was held on January 23, 2009. One of the major accomplishments of the summit was the beginning of a state oral health plan. The Oral Health Summit identified stakeholders to form partnerships and a coalition to work at the workforce level on access to care and prevention/education. The 2007 C&TC Oral/Dental Health online modules continue to be used by public and private providers and are updated annually.

c. Plan for the Coming Year

Meeting the oral/dental health needs of young children (0-5 years) is of high priority for Minnesota's early childhood stakeholders which are supported by the Minnesota Early Childhood Comprehensive Systems (MECCS) project. The MDH has identified oral health needs as one of their priority issues.

Minnesota has received funding from the CDC for a 5-year Oral Health Prevention Program. The Oral Health Program is housed in the Center for Health Promotion at the MDH. The grant's purpose encompasses eight areas as outlined: 1) Staffing: creating an oral health staff to increase infrastructure; 2) Surveillance: creating a surveillance plan and data collection to share information about the state's oral health needs; 3) Planning: creating a state oral health plan to strengthen the state's ability to promote oral health through purposeful, evidence-based planning, policy initiatives and development; 4) Partnerships: developing an oral health coalition with a focus on advocacy activities leading to sustainable oral health promotion activities; 5) Prevention: creating a school-based/linked sealant program to build the capacity of prevention programs, form partnerships to better utilize resources and lead to sustainable oral health promotion activities; 6) Policy: identification of opportunities to make changes in policy and health systems to overcome barriers, capitalize on assets, increase capacity and coordinate oral disease prevention interventions; 7) Evaluation: to measure program progress, community capacity changes and outcomes to improve Minnesota oral health and address disparities; 8) Integration: developing partnerships in oral health to promote leveraging of resources and coordination of effective public health prevention initiatives.

As part of the Oral Health Program, an oral health surveillance team will be developed to coordinate data collection in cancer, birth defect, tooth loss, community water fluoridation, third grade student oral health, sixth/ninth/twelfth grader risk behaviors, emergency department statistics and workforce database accessibility. The MCH Epidemiologist has been invited to participate on the oral health surveillance team. The Oral Health Program will continue to

develop the systems for planning, partnerships, prevention, policy making, evaluation of programs, and integration of effective public health initiatives as they relate to oral health in Minnesota.

The Title V staff involved in C&TC education training will continue to support and advance oral health promotion and screening as a priority in the Medical Assistance population. This will be accomplished through provider workshops, online resources, and state and local meetings.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	2.5	2.4	3.2	2.3	2
Annual Indicator	3.4	2.4	2.2	1.9	
Numerator	35	24	23	20	
Denominator	1030130	1005572	1030354	1035183	
Data Source					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	1.9	1.9	1.5	1.5	1.5

Notes - 2008
2008 data not yet available.

Notes - 2007
2007 data not yet available

Notes - 2006
2006 data are not yet available.

a. Last Year's Accomplishments
The motor vehicle crash child death rate (birth to age 14) of 2.2 per 100,000 in 2006 dropped to 1.93 in 2007. This progress offers encouragement for Minnesota to continue educational and enforcement initiatives, combined with providing car seats and booster seats to those who need them. The activities that contributed to reducing risk of injury in a motor vehicle-related crash included: 1) statewide distribution of car seats and booster seats to those in need; and 2) intensive training of public health staff and local volunteers in proper car seat and booster seat installation, combined with educational techniques and approaches for families to whom car / booster seats are given. These activities were accomplished in partnership and collaboration with Minnesota Safe Kids, the Department of Public Safety, local health departments and trauma centers across Minnesota.

More than 1,000 car seat safety specialists have passed child passenger safety training and are available to assist and to serve in communities across Minnesota. These specialists are listed by county on the searchable web site maintained by our partners at the Department of Public Safety, Office of Traffic Safety (http://www.dps.state.mn.us/ots/CPS_Program/childhome.asp). The

Minnesota Legislature strengthened our state's graduated driver's license law that restricts the number of teen passengers for teen drivers aged 16 and 17 and reduces nighttime driving exposure.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Distribute car seats and booster seats to families; teach proper installation and use.	X	X		
2. Train car seat and booster seat checkers.			X	X
3. Support the GDL and “Click it or ticket” campaigns of OTS, Department of Public Safety.				X
4. Support, through data analysis, the shift in MN to standard enforcement of seat belts (Every body, every seat, every time).				X
5. Continue emphasis in Positive Alternatives, Family Home Visiting and C&TC on using the home safety checklist with families being served.			X	X
6. Support enforcement of speed limits, prevention of distracted and drowsy driving, and reduction of impaired driving, which place children at risk.			X	X
7. Promote seat belt use for children.		X	X	
8. Promote safe routes and walkable communities for children		X	X	
9. Promote safe bicycling routes and practices for children.		X	X	
10. Promote crosswalk and pedestrian safety for children.		X	X	

b. Current Activities

Programs continued to distribute car/booster seats and train providers and parents on correct installation and use. Providers at clinics, hospitals and LHDs continue to encourage appropriate restraint usage in motor vehicles by all population sub-groups.

The C&TC program provides training sessions that includes guidance on safety issues including car seats and seat belt use. The best practice literature suggests that health professionals champion motor vehicle safety as an aspect of their responsibilities; crash death rates will be reduced. Correct restraint needs to be modeled by parents and caregivers, taught by health professionals, and car/booster seats need to be provided to those who otherwise would not be able to afford them.

Excess speed, lack of seat belt use, distracted and drowsy driving remain concerns across all ages, but have particular impact on persons aged birth through 14 years of age. Minnesota's legislature passed House File 108, which makes non-seat belt use a primary offense in Minnesota. Governor Tim Pawlenty signed the bill into law and it takes effect on June 9, 2009. MN legislators also approved -- and the governor signed - a strengthened and improved booster seat bill that, effective July 1, 2009, that requires children under age eight or under four feet nine inches to ride in an approved booster seat. Continued improvements in Minnesota's EMS and trauma care systems will also reduce the risk of motor vehicle crash-related death.

c. Plan for the Coming Year

Activities described in Current Activities will continue, with ongoing emphasis on recent immigrants from West Africa, Somalia, Sudan and Southeast Asia (Myanmar, Laos and Vietnam).

New funding for child car restraints and appropriate parental safety training has enabled local non-profit organizations to identify and support low-income families in the use of appropriate child restraints. However, the need far surpasses available funds and great gaps persist.

For families who do not qualify for an assistance program, new car seats can be found across Minnesota at various stores. If a used car seat is obtained, parents are encouraged to ensure that the seat is safe by assuring that the seat is less than six-years old and has never been involved in a vehicle crash. Parents are discouraged from using car seats missing the label with the manufacturing date, model number and original instructions, or one that has missing or broken parts. Parents are advised to not purchase used car seats through garage sales or second-hand stores.

Car seat inspection clinics will continue. These vary from a one-day event to an on-going service that an agency provides (a fitting station). At these clinics, trained technicians will inspect car seats as they are currently installed within a vehicle. Trained staff members mostly come from fields within public health, law enforcement, healthcare, and EMS/Fire. Overall, however, very few communities around the state of Minnesota offer this valuable service. Many agencies will continue to try to incorporate car seat checks as part of other programs. These agencies use a variety of blended funding sources to support this critical community-level intervention.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			45	48	48
Annual Indicator	44.3	46.5	46.5		
Numerator					
Denominator					
Data Source					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?					
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	48	49	50	50	50

Notes - 2008
2008 data not yet available. May be available on NIS web site 8/09.

Notes - 2007
2007 data will not be available until 8/09 on NIS web site.

Notes - 2006
2006 data are not yet available. The amended, final percentage for 2005, based on CDC's 2005 Breastfeeding National Immunizations Survey, is 46.5% of mothers. Sample represents 340 women.

a. Last Year's Accomplishments

Minnesota continues to strongly promote breastfeeding of all infants. However, challenges remain. The percentage of mothers who breastfeed at 6 months has dropped slightly from 46.5% in 2006 to 45.9% in 2007.

In other breastfeeding success measures, Minnesota has met the Healthy People (HP) 2010 goal

for breastfeeding initiation and MDH continued to work to promote and support breastfeeding for all Minnesota mothers and infants. Breastfeeding initiation rates for some population groups, including refugee and low-income populations, are still lower. The Hmong and Somali populations have lost breastfeeding traditions upon immigration to the United States, the Hmong often ceasing to breastfeed and the Somali often breastfeed with supplementation and shorter duration than before immigration. Native Americans also breastfeed at lower rates than the general population. Rates vary considerably between Minnesota communities. We have made progress, but numerous barriers to breastfeeding remain.

Breastfeeding is encouraged and supported through the MDH Family Home Visiting (FHV) program, and other local health department activities, including breastfeeding support groups and educational offerings. Breastfeeding materials, such as best practices and resources, were distributed through FHV e-mail lists and posted on the FHV website. The Minnesota WIC program implemented multiple activities to promote and support breastfeeding.

Breastfeeding information for parents and professionals is available on the Minnesota WIC website. WIC updated their breastfeeding promotion and support guidance document, incorporating strategies and messages to increase breastfeeding exclusivity. The new document was available on the WIC website in the summer 2008. In 2007, WIC sponsored breastfeeding workshops in Northeast, Southeast and Southwestern Minnesota. WIC, local health department, hospitals, clinics and voluntary organization staff attended the workshops. Several counties have reported changes in practice, including changes in hospital practice, following the workshops. WIC supplemental funding projects have led to development of several local breastfeeding coalitions. Minnesota now has 23 local breastfeeding coalitions. Breastfeeding information were made available in English, Spanish, Somali, and other languages.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assure that MCH Public Health Strategies on breastfeeding promotion continue to be available			X	X
2. Support breastfeeding promotion and support as a component of the Family Home Visiting services.	X			X
3. Continue to provide breastfeeding education and support through WIC, i.e. training and technical assistance to local WIC programs, and local programs provide breastfeeding support services to WIC participants.	X		X	X
4. Provide technical assistance and training to local programs to help them identify opportunities and implement strategies to promote and support breastfeeding.			X	X
5. Continue WIC Peer Breastfeeding Support Grants and TA to grantees	X			X
6. Convene cross-program meetings to identify ways to integrate breastfeeding promotion & support into a wide array of MCH programs.				X
7. Propose policies that support breastfeeding.			X	X
8.				
9.				
10.				

b. Current Activities

Title V staff and the WIC programs continue to collaborate to promote and support breastfeeding. LHDs, supported by Title V, advocate breastfeeding and include breastfeeding promotion strategies with families.

WIC provides leadership for activities to promote and support breastfeeding. WIC continues to offer workshops on breastfeeding counseling and breastfeeding information is available on the WIC website.

The Minnesota Breastfeeding Coalition (MBC) held a statewide meeting in November 2008 for an expanded membership and to form work groups. Work groups were formed to address six strategies identified by the CDC that are evidence-based for increasing breastfeeding initiation and duration: maternity care practices, workplace support, peer support, educating mothers, professional support, and media and social marketing. An MCH representative participated in this meeting and will participate in the ongoing activities of the MBC. As of September 2008, the MBC produced a map of Minnesota showing sites of 25 local Breastfeeding Coalitions. MBC has hosted conference calls for education and information sharing among the local coalitions.

Breastfeeding continues to be encouraged and supported through the MDH Family Home Visiting program, and other local health department activities, including breastfeeding support groups and educational offerings. Breastfeeding materials, such as best practices and resources, are distributed through FHV e-mail lists and posted on the FHV website.

c. Plan for the Coming Year

MDH will continue to develop linkages to promote and support breastfeeding, including meeting with MCH and WIC staff to discuss breastfeeding promotion and support, and practices within communities that can hinder breastfeeding. We will also continue to place special emphasis on our newest cultural/ethnic populations. We plan to investigate partnering for breastfeeding training and to explore opportunities to incorporate information regarding breastfeeding and cultural practices related to breastfeeding in the foundations training being developed for family home visitors. We will continue to provide current and relevant breastfeeding information to local public health staff, and work on the consistency of breastfeeding messages between programs and between staff within programs and communities.

MDH will provide breastfeeding information and resources to Positive Alternatives grantees. The Positive Alternatives Program is a grant program designed to support women in maintaining their pregnancies and supporting their infants after birth. The programs funded through Positive Alternatives are in a position to encourage and support women who choose to breastfeed.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	98	98	98	90	85
Annual Indicator	96.5	85.2	80.2	88.9	
Numerator	68123	59657	60683	65434	
Denominator	70579	70030	75656	73608	
Data Source					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

	2009	2010	2011	2012	2013
Annual Performance Objective	90	90	90	90	95

Notes - 2008
data not available for 2008

Notes - 2007
2007 data not yet available

Notes - 2006
2006 data are not yet available.

a. Last Year's Accomplishments
In 2007 Early Hearing Detection and Intervention (EHDI) legislation passed that required mandatory reporting to the state health department for screening failures and for diagnostically confirmed hearing loss. Newborn hearing screening is the first part of a comprehensive EHDI program in Minnesota. The Public Health Lab within the Minnesota Department of Health (MDH) is responsible for managing the screening program and the screening is actually done in the hospital. Screening results and audiologic results must be reported to MDH. The Minnesota Children with Special Health Needs (MCSHN) program is responsible for long-term follow-up services to families once a diagnosis has been confirmed. MCSHN will ensure appropriate and timely intervention and connections for families with statewide services and resources. The 2007 EHDI legislation requires tracking of children with a confirmed hearing loss until they reach 18 years of age.

97.5 percent (70,902/73,080) of the newborns born after the mandate was implemented (September 1, 2007) were screened for hearing. Results are reported on the dried blood spot form and then matched with birth certificates. About 5.2 percent (3,752/70,902) of newborns failed the screen at the hospital. During this time period 164 infants were reported to have a hearing loss and 103 of those infants had permanent hearing loss.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide technical assistance on implementing newborn hearing screening to hospitals & communities				X
2. Provide education & training of providers, including Audiologists		X	X	X
3. Provide information to parents of the importance of screening & if identified with a hearing loss, additional follow-up		X	X	X
4. Refine & expand the data tracking & follow-up system			X	X
5. Integrate data collection, follow-up & tracking with newborn blood spot screening			X	X
6. Work with a variety of stakeholders on assuring follow-up, referral & intervention for infants		X	X	X
7. Continue federally funded grant activities in this area		X	X	X
8. Support hospital quality assurance activities				X
9.				
10.				

b. Current Activities
The MCSHN section is collaborating with key stakeholders to implement a quality improvement project called the EHDI Community Collaborative. The aim of the overall Collaborative is to

improve the health and well being of children with permanent hearing loss and their families, through enhancing capacity and coordination of public health, education, social service and parent-to-parent support systems to create and sustain effective community based systems of care. The measures reflect that all newborns will receive timely referrals, complete diagnostic evaluations, and appropriate linkages to all supportive services and resources. There are 17 regional EHDI in the state and four of them participate in the collaborative by attending learning sessions, participating in monthly conference call, and reporting data to the state on a monthly basis.

EDHI follow-up staff from MCSHN continue to work with their counterparts in the lab to improve hearing screening protocols and outcomes. Staff from both areas participated in the second NICHQ sponsored national collaborative on Epilepsy and Newborn Hearing Screening and representatives from the Minnesota team were asked to serve as faculty for the third collaborative which began in June. MCSHN-EDHI and Lab staff are working increase the efficiency and are also working on a major revision of the Lab's information system for short term and long term follow-up and will provide longitudinal information on infants with confirmed hearing loss.

c. Plan for the Coming Year

The MCSHN program will continue to implement the EHDI Community Collaborative by adding 2-3 additional regional EDHI teams. The collaborative will have new data to share and hopefully demonstrate regional and state improvements in all areas. In addition, a new web based reporting system will be tested and piloted for audiologists, primary care providers, and early interventionist. The new system will provide an opportunity for data integration with other child health data systems, such as vital records, immunization, birth defects and WIC to assure that children are not lost to follow-up in the EHDI process.

MCSHN has applied for supplemental funding to reduce loss to follow-up of infants with a confirmed permanent hearing loss. If funded, these resources will be directed to follow-up loss of infants not screened in the hospital, lost between screening and re-screening, lost between re-screening and diagnosis and lost between diagnosis and enrollment in early intervention.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	2.4	2.2	7.5	7	5.5
Annual Indicator	7.9	7.9	6.0	6.0	
Numerator	98354	97554	75476	75600	
Denominator	1240280	1229578	1254930	1257000	
Data Source					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	5.5	5	5	5	5

Notes - 2008

2008 data not available. Survey is not conducted every year.

Notes - 2007
2007 data not yet available

Notes - 2006
The 2006 data are not yet available.

a. Last Year's Accomplishments
At the end of each legislative session, Title V CSHCN staff update MAZE training materials. MAZE stands for Taking the MAZE out of Funding. These materials reflect eligibility criteria and benefits coverage for Minnesota's publicly-funded health insurance programs, which include Medical Assistance (Medicaid), MinnesotaCare, home and community-based waivers. Title V CSHCN staff then conduct trainings throughout the state for providers, social service staff and families. In 2007-08 staff trained 978 people in 45 trainings. Over the past 5 years (2003-2008) nearly 5,000 people have been trained in 213 trainings.

Staff in the Family Home Visiting, Positive Alternatives Program, Family Planning Special Projects and WIC programs continued to emphasize to grantees the importance of assessing insurance status and the referral of clients to appropriate resources.

Minnesota's local health departments (LHDs) are required to report on their progress toward the achievement of a number of outcome measures. One of these measures is to increase the number of clients enrolled in health insurance programs. To measure progress toward this outcome, LHDs are asked to annually indicate: 1) those programs in which they routinely assess the health insurance status of clients; and 2) those programs in which they refer clients without insurance to appropriate insurance resources. LHDs are asked these questions about a wide range of public health programs. Following is a summary of their performance (for the 2008 calendar year) in the programs that are most likely to reflect on the insurance status of children. Early intervention service coordination for CSHN: 91 percent assessed insurance status, 93 percent referred to resources. WIC clinics: 92 percent assessed insurance status, 95 percent referred to resources. Family home visiting: 96 percent assessed insurance status, 94 percent referred to resources. CTC Outreach: 88 percent assessed insurance status, 88 percent referred to resources. Follow-along program: 72 percent assessed insurance status, 79 percent referred to resources.

The MDH in partnership with the University of Minnesota has periodically conducted the Minnesota Health Care Access Survey over the last 12 years. These surveys are the source of data for state policy makers to define and respond to health insurance issues of Minnesotans. The most recent survey, conducted in 2007, reports that Minnesota's rate of overall uninsurance remained stable since 2004, the last time the survey was conducted. About 7.2 percent of Minnesotans were without insurance in 2007.

Residents covered by publicly-funded state programs like Medical Assistance or MinnesotaCare remained relatively stable at 25.2 percent. There was a decrease in the number of uninsured children between the ages of birth to 5 (from 7.4 percent in 2004 to 5.5 percent in 2007). However, in children between the ages of 6 and 17 the number increased from 10.3 percent in 2004 to 15.2 percent in 2007. The vast majority of these uninsured children are eligible for either MinnesotaCare or Medical Assistance.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide MAZE trainings for parents and professionals		X		X
2. Partner with DHS to assure that all children eligible for public		X	X	X

programs are enrolled				
3. Work within existing systems to assist families in identifying insurance options				X
4. Continue to participate on the Build Initiative		X		X
5. Update and distribute the Part C Central Directory			X	X
6. Maintain insurance coverage component of the Family Home Visiting program			X	X
7. Develop communication plan for using information related to health insurance to educate and inform providers, families, planners and policymakers				X
8. Participate on Department priority area of Health Care reform activities				X
9. Continue to monitor insurance referral reporting in local public health programs				X
10.				

b. Current Activities

The 2008 Legislature, responding to a $1 billion deficit in its SFY 2009 budget considered a number of proposals affecting eligibility for Medicaid and MinnesotaCare. Changes passed by the Legislature and adopted by the Governor were analyzed and incorporated into the MAZE training. Minnesota, as is true for other states, also faced a significant estimated budget deficit for the SFY 2010-11 biennium (in excess of $6 billion dollars). The 2009 Legislature and the Governor could not agree on a budget and the Governor is using his unallotment power to balance the budget. He did eliminate a health insurance program called General Assistance Medical Care (GMAC) effective July of 2010. This program is limited to low-income adults with no dependent children, who do not qualify for Medicaid and are between 21 and 64.

Minnesota's LHD continue to assess the insurance status of clients in multiple public health programs, including home visiting, WIC, early intervention services, C&TC, and the Follow-Along Program. MDH will support LHD in this effort.

The state will conduct its Health Care Access survey in the fall of 2009. Title V was successful in including a question on disabilities in this survey. Survey results will be released early in 2010.

c. Plan for the Coming Year

MAZE training material will be updated throughout the summer based on legislative changes during the 2009 session. Beginning in late 2009, Title V staff will conduct trainings throughout the state on eligibility criteria and benefit coverage of the state's publicly-funded programs. Title V staff continue to work closely with their Title XIX colleagues on a myriad of topics and program implementation challenges and will continue to do so. Results of the Health Care Access survey will be available and used where appropriate, in policy decision affecting eligibility criteria for children's enrollment in Medical Assistance (Medicaid) and MinnesotaCare.

The MDH will continue to work with LHD to monitor rates of insurance referral reporting of clients in public health programs as a way to monitor progress toward the statewide goal to increase the number of clients who are enrolled in health insurance programs.

Minnesota participates in the Early Childhood Comprehensive System (ECCS) initiative funded by the federal Maternal and Child Health Bureau. A key component of that system is to address the need for access to comprehensive health services and medical homes, including assuring access to insurance resources.

Minnesota is one of 5 states participating in the Build Initiative -- a national multi-state partnership that supports efforts to make sure that children from birth through age five are safe, healthy, and

ready to learn. The Build Initiative's lead organization in Minnesota is Ready 4 K, a Minnesota non-profit advocacy group. The state health department, through its ECCS initiative, works in partnership with Ready 4 K and multiple other partners to assure a coordinated system of care for children, including have access to health insurance resources. The department has received continuation funding from the MCHB for Minnesota's ECCS initiative. The department, through its ECCS initiative, will continue to partner with Ready 4 K and the Build Initiative.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			29	28.5	28
Annual Indicator	30.7	29.7	30.4	29.9	30.4
Numerator	14701	16723	17502	18272	19944
Denominator	47885	56307	57609	61109	65607
Data Source					PedNSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	28	27	26.5	25	25

Notes - 2008
2008 data not yet available.

Notes - 2006
Final data for 2005 are as follows:
Indicator = 29.7%
Numerator = 16,723
Denominator = 56,307
Data reported in the 2005 column are based on the 2004 PedNSS.

The 2006 data are not yet available.

a. Last Year's Accomplishments
The MN WIC Program requires local WIC programs to assess the weight status of all children participating in WIC, and tracks the incidence of overweight throughout the year and across years via reports. MDH staff monitor these reports.

With the relatively high incidence of obesity in children, the state WIC Nutrition Education Plan (NEP) for FY 2007-2008 focused on preventing childhood obesity, with one of the goals being "to help parents prevent overweight in their children by influencing their health-related knowledge, attitudes and behaviors." This was accomplished through targeted training of local WIC staff in child nutrition and effective counseling strategies; providing educational tools for local WIC staff to use for promoting healthy eating and physical activity; encouraging WIC staff to model healthy eating and physical activity; and promoting local agency collaboration with community partners to address childhood obesity. A second goal was to increase the duration of breastfeeding among WIC participants. State WIC staff worked with local WIC staff to develop and implement their

agency's NEP.

Title V staff in the Child and Teen Checkups program (C&TC - Minnesota's EPSDT) provided training to measure height and weight and tabulating BMI. Three workshops were held across the state and participants included public and private providers of C&TC. The use of the Healthy Eating and Activity Together (HEAT) toolkit in the C&TC refresher was evaluated in 2007/2008 and found not to be cost-effective.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Weigh and measure (twice/year) children ages 2-5 participating in WIC, plot data on growth grids and calculate BMI.				
2. Identify children at-risk-of-overweight or overweight, using BMI.				
3. Provide referrals to primary health care provider and other health and social services as needed.				
4. Counsel caregivers and provide nutrition education (e.g. related to feeding practices, diet and physical activity).				
5. Tailor the WIC Food package to best meet child's dietary needs.				
6. Transmit anthropometric data to CDC for PedNSS reports.				
7. Share anthropometric data summaries with local and state stakeholders to guide policy decisions.				
8. Participate on development of Obesity State Plan Development				
9. Incorporate appropriate referral mechanisms to WIC from other child programs such as home visiting, Follow-Along Program, Positive Alternatives grantees, etc.				
10. Provide obesity prevention and screening education and training to pediatric C&TC providers.				

b. Current Activities

In anticipation of the new WIC Food Package, the WIC Program is focusing on revising food package policies, developing the new Food List, and preparing local WIC staff to implement the new food package. The WIC Program prioritized food packages that promote healthy eating, beginning with breastfeeding in infants' early days. Another change is the requirement that all children > 2 years of age, receive only lowfat or fat-free milk, and that children be limited in the amount of cheese they receive. These policies, in addition to the new foods being added (fruits, vegetables, whole grains) will promote healthier, more well-balanced diets.

The WIC Program also needed to establish new vendor requirements for stocking the new foods. The program used this opportunity to promote healthy food options and influence the "food environment" of communities by requiring authorized stores to stock a specified amount of lowfat milks and fresh fruits and vegetables.

In early 2009 Title V staff in the C&TC program conducted a survey of C&TC coordinators across the state regarding C&TC training needs. Information from the survey indicates that C&TC providers need further training on best practices in well child care including height, weight and BMI. C&TC staff have done presentations to Head Start staff on the health performance measures for Head Start, with a specific component relating to BMI in young children.

c. Plan for the Coming Year

In the coming year, the MN WIC Program will resume training to build local WIC staff skills to engage WIC participants and more effectively counsel, educate, and influence food choices and feeding practices. Staff identifies this as their greatest challenge.

The Title V staff will continue to research programs and provide best practices to prevent obesity in children and young adults through education and training of private and public C&TC providers. Title V staff have been invited by the Obesity Team at MDH to participate in planning.

One significant opportunity is the implementation of the Statewide Health Improvement Partnership (SHIP). The 2008 Minnesota Legislature passed comprehensive legislation to support a SHIP will provide funding ($47 million over the next two years) through grants to local health departments and tribal governments across Minnesota. Grantees will be required to create community action plans, assemble community leadership teams, and establish partnerships. Grantees will utilize policy, systems and environmental changes in four settings: schools, work sites, health care and community. SHIP efforts will focus on obesity (through physical inactivity and unhealthy eating) and tobacco as the key risk factors to target interventions in fiscal years 2010-2011. Title staff will continue to work with SHIP staff, LHD and tribal governments to integrate interventions that will address the obesity in children.

The MDH WIC and C&TC programs, in partnership with the Minnesota Department of Human Services will distribute the "Healthy Families: food, fun & facts" cookbook. This cookbook will be distributed to WIC participants to provide healthy family recipes based on the WIC food plan. The cookbook with also be used as an outreach tool to connect WIC families the C&TC services.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			13	13	13
Annual Indicator	15.9	14.9	13.6	15.0	
Numerator	10533		9427	10303	
Denominator	66095		69367	68911	
Data Source					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	13	13	13	12	12

Notes - 2008
2008 PRAMS data not yet available.

Notes - 2007
2007 data not yet available

Notes - 2006
The 2006 PRAMS data are not yet available. The most recent PRAMS data available are for 2004 and are as follows:

Indicator = 15.9%
Numerator = 10,533
Denominator = 66,095

a. Last Year's Accomplishments
The State Team on Tobacco Prevention for Women of Childbearing Age including Pregnant Women (State Team) continued to meet and implement activities. This team is comprised of Title V staff, staff representing MDH's Tobacco Prevention and Control Section, Planned Parenthood of MN/SD, Minnesota American College of Obstetricians and Gynecologists (MN ACOG), the Minnesota March of Dimes, and local public health department (LHD) staff.

Minnesota's Freedom to Breathe Act requiring smoke free indoor air was implemented October 1, 2007. Most adult non-smokers are now protected from exposure to secondhand smoke (SHS) leaving infants and children as the population of non-smokers most exposed in their homes and in cars. State Team members presented at the January 2008 Birth to Three Conference to encourage attendees to implement the "5A's" best practice intervention for smoking cessation in pregnancy and provided strategies and resources to prevent postpartum relapse and SHS exposure for infants, children, and pregnant women.

MCH staff continued to participate in quarterly training for new WIC staff and provide information on "2As and an R" (Ask, Advise and Refer) and other resources they can incorporate into WIC counseling. WIC staff are encouraged to refer participants to Minnesota's Quit Line program and to provide information on protecting infants, children, and pregnant women from secondhand smoke.

In June 2008, through a partnership with the Metropolitan Health Plan (MHP) and Twin Cities Healthy Start, the State Team presented their second conference to 56 attendees on using the "5 As" to reduce smoking in pregnancy. Conference participants were racially and ethnically diverse and repreresented a variety of community-based programs in Minneapolis and St. Paul. Special emphasis was placed on strategies to reach teen smokers including those smoking marijuana during pregnancy.

The State Team continued to disseminate professional and patient education materials to LHD and community-based organizations through the "Save A Bundle" project. The materials include information on implementing the 5 A's, referring to Minnesota's Quit Plan for cessation phone counseling, preventing postpartum relapse and reducing SHS.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Access MN vital record, PRAMS and WIC databases for baseline incidence of smoking in pregnancy and ethnic/racial disparities			X	
2. Implement with partners the Smoking Cessation for Women State Plan		X		X
3. Repeat and extend training for smoking cessation			X	X
4. Reach out to diverse community partners for training opportunities			X	X
5. Work with others within the Department (OMMH) and external partners, (ACOG and midwives) to identify strategies on effectively reaching high-risk populations.				X
6. Integrate the "stop smoking" message with other health promotion messages targeted to young women.			X	
7.				

8.				
9.				
10.				

b. Current Activities
Title V staff trains all new WIC staff on "2 As and an R" for smoking cessation during pregnancy and postpartum, and to reduce exposure to SHS.

Staff provides support to LHD and program grantees on the "5 A's" for smoking cessation in pregnancy and reducing exposure to SHS. LHD are encouraged to attend a motivational interviewing training to implement this intervention.

Staff work to promote safe infant sleep with the "Safe and Asleep in a Crib of Their Own" campaign and SIDS risk reduction with the MN SID Center. Smoking cessation is integrated into all messages. Work with Twin Cities Healthy Start focuses on smoking reduction in pregnancy and SHS reduction for pregnant women and infants to reduce infant mortality, low birth weight, SIDS and other sleep-related infant deaths.

A Community Action Team was developed to implement the recommendations from the American Indian Infant Mortality Review project (conducted in 2007). Work groups were formed, one to promote SIDS risk reduction and other safe sleep interventions. The reservation communities and urban Indian agencies receive state funding to reduce health disparities that enable them to develop cultural safe sleep and SHS reduction materials.

Title V staff is working with the MCH Tobacco Section to identify opportunity for partnership following the reassignment of staff to cardiovascular activities. Due to the end of a CDC grant, the Tobacco Section is also no longer able to continue the "Save A Bundle" project.

c. Plan for the Coming Year
Title V staff will continue to work with the State Team to address smoking during pregnancy and second hand smoke. There have been some recent hurdles that will impact activities for the coming year. As noted above, staff from the MDH Tobacco Section have been reassigned to address other issues. In addition, a small AMCHP mini-grant has ended. This grant provided popular educational materials to many direct service organizations, especially urban Indian and reservation health programs. The MDH MCH staff will be identifying new opportunities to address this issue.

One significant opportunity is the implementation of the Statewide Health Improvement Partnership (SHIP). The 2008 Minnesota Legislature passed comprehensive legislation to support a SHIP will provide funding ($47 million over the next two years) through grants to local health departments and tribal governments across Minnesota. Grantees will be required to create community action plans, assemble community leadership teams, and establish partnerships. Grantees will utilize policy, systems and environmental changes in four settings: schools, work sites, health care and community. SHIP efforts will focus on obesity (through physical inactivity and unhealthy eating) and tobacco as the key risk factors to target interventions in fiscal years 2010-2011. MCH staff will continue to work with SHIP staff, LHD and tribal governments to integrate interventions that will address the needs of pregnant women and secondhand smoke.

In addition, Title V staff will continue the following activities in the coming year: 1) Trainings and technical assistance for MDH grantees, LHD, WIC and community-agency staff on implementing the "5 A's" and reducing SHS exposure, 2) working with the Community Action Team of the American Indian Infant Mortality Review project, and 3) technical assistance and consultation to Twin Cities Healthy Start.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	8.2	8	9.8	11	8.5
Annual Indicator	10.0	11.7	8.9	9.7	7.3
Numerator	38	44	33	36	27
Denominator	378976	375522	372719	371683	371683
Data Source					State Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	7.2	7.1	7	6.9	6.8

Notes - 2008
2008 Population count not yet available.

Notes - 2007
2007 data not yet available

Notes - 2006
The 2006 data are not yet available.

a. Last Year's Accomplishments
In the fall of 2007 the state departments of health (MDH) and human services (DHS) agreed to combine funds for suicide prevention. Funding from the SAMHSA Community Mental Health Block Grant was combined with the 2007-2008 state appropriation for suicide prevention. In addition, the CYSHCN program added state funds from its clinic program, providing a combined total of $800,000 for a two year period. An RFP process was completed in the spring of 2008 and MDH awarded five grants for suicide prevention. Each grantee was awarded $180,000 over a twenty-two month period to engage in evidence-based suicide prevention activities, including public education, gatekeeper training for both youth and adults, community organizing, and culturally specific prevention activities in tribal communities. Grantees will engage in activities to address suicide across the lifespan, including youth and older adults. Program activities began in May, 2008 and funded programs will complete their work plans in the coming year.

MCH and CYSHCN staff continued work on mental health initiatives regarding screening for socio-emotional and/or mental health concerns, crisis intervention services for youth and innovative approaches to increasing access to mental health services. MDH sponsored four suicide prevention trainings for health care professionals and collaborated with community partners to provide an educational workshop on preventing suicide contagion.

Staff in both the CYSHCN and MCH programs continued to work collaboratively with partner organizations and state agencies to support suicide prevention efforts and build resiliency for youth in Minnesota. Staff participated in the Children's Subcommittee of the State Advisory

Council on Mental Health.

MDH hired a new Suicide Prevention Coordinator in August, 2008. The coordinator will provide technical assistance on suicide prevention, monitor grant activities, monitor implementation of the state suicide prevention plan, collaborate with public and private partners, and provide education and training on topics related to suicide prevention.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor and implement state suicide prevention plan.			X	X
2. Technical assistance to public health and other community agencies				X
3. Participate actively on the Children's Subcommittee of the State Advisory Council on Mental Health				X
4. Continue to support youth activities that support resiliency and healthy behaviors			X	X
5. Continue to analyze student survey data to identify populations at high risk				X
6. Collaborate with public and private partners in suicide prevention			X	X
7. Implement and monitor suicide prevention grants		X	X	X
8. Implement statewide public education campaign for suicide prevention			X	
9.				
10.				

b. Current Activities

Staff currently monitor grant activities, provide training and technical assistance to individuals and organizations throughout the state, and collaborate with other key stakeholders in suicide prevention including the state departments of corrections (DOC), education (MDE) and human services (DHS) as well as local nonprofit organizations. Staff participates on the Children's Subcommittee of the State Advisory Council on Mental Health and meets regularly with a workgroup on health education facilitated by the department of education.

One of the grantees, Suicide Awareness Voices of Education (SAVE), has finalized a statewide public education campaign targeting gatekeepers for four high-risk populations: youth, adult men, older adults, and American Indians. Dissemination of campaign materials will take place in late spring. SAVE is also providing training to communities around working with media.

In March of 2009 MDH hosted a day-long workshop with Dr. Teresa LaFromboise, who developed the American Indian Life Skills Development Curriculum, a culturally specific suicide prevention curriculum. In April 2009, the Title V program submitted a youth suicide prevention grant to SAMHSA (Garrett Lee Smith Act funding).

Staff continues to monitor surveillance data and develop expertise in evidence-based strategies. The Title V program also expects to update its website with current information on suicide and evidence-based strategies for suicide prevention by the end of the year.

c. Plan for the Coming Year

Staff will continue to monitor grant activities and promote the use of evidence-based suicide prevention activities. Current grants end in March of 2010 and a new grant cycle will be initiated

pending availability of state and/or federal funding. MDH will continue to provide technical assistance to individuals and organizations throughout Minnesota and conduct workshops at relevant meetings and conferences.

Title V will work with public and private partners in suicide prevention to improve outcomes for youth involved in various systems, including corrections, child welfare and education. It will also work with community partners to offer educational opportunities for school personnel, mental health professionals, community organizations and other interested parties. And, it will continue to work on mental health initiatives regarding screening for socio-emotional and/or mental health concerns.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	80	82	86	87	84
Annual Indicator	84.6	84.1	83.2	85.6	
Numerator	654	702	674	718	
Denominator	773	835	810	839	
Data Source					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	87	87	88	88	89

Notes - 2008
2008 hospital data not available yet.

Notes - 2007
2007 data not yet available

Notes - 2006
The 2006 data are not yet available.

a. Last Year's Accomplishments
In 2007, 85.6 percent of very low birth weight infants (infants weighing 1,500 grams or less) were born in facilities appropriate for high-risk, very low birth weight deliveries. This represents an increase from 2006. Minnesota has made some progress on this indicator toward the objective of 87 percent.

The Minnesota Perinatal Organization (MPO), Twin Cities Healthy Start, and the Minnesota March of Dimes are examples of organizations focusing on healthy pregnancy outcomes. Title V staff worked with both organizations on program planning for health professionals. The MPO targets all health professions involved in perinatal care. This organization provided an educational conference to improve the health care of pregnant women and newborn infants. The March of Dimes focuses on both consumer and professional education. Title V and other MDH staff work closely with the March of Dimes to address professional and consumer education on folic acid, preconception care, disparities in infant mortality and birth defects. Title V staff collaborated with

the March of Dimes on their prematurity education and research campaigns. Title V staff and the March of Dimes, with others, collaborated on Minnesota's first preconception care conference (October 2007) and in planning the second preconception care conference held in November 2008.

Title V staff provided technical assistance and consultation to Twin Cities Healthy Start, an agency working with women at high risk for delivering VLBW babies. Pregnant women are assessed for risk factors using a web-based assessment tool called the Pregnancy Risk Overview (PRO) and, based on those results, are enrolled in prenatal care at the appropriate level for their risk of VLBW. They are followed closely throughout pregnancy to assure their social risk factors are addressed and to assure they get the medical care they need to improve their birth outcomes. This includes delivery at a Level III hospital.

Title V staff participated in biannual Maternity Case Management Excellence regional meetings. These meetings are hosted by the Minneapolis Department of Health and Family Support and include clinical, public health, health plan, and community-based program staff. Disciplines included clinic nurses, case managers, community health workers, outreach workers, doulas, public health nurses, social workers, and child birth educators. The purpose of the meetings is to share resources, promote collaboration, discuss barriers and current trends, and particularly to promote and improve coordination of care for high risk pregnant women. There is much emphasis on promoting culturally sensitive care and raising awareness of cultural issues that impact pregnancies and births.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor the status of perinatal centers in Minnesota				
2. Collaborate with external partners such as the March of Dimes, Twin Cities Healthy Start, and the MN Perinatal Organization				
3. Promote guidelines for Perinatal Care				
4. Monitor the number and place of birth for high-risk deliveries				
5. Actively participate in maternal case management collaborative meetings to improve maternity and infant care for diverse and low-income families.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

138 people attended the 2nd preconception care conference. The conference, "Reaching Underserved Populations," received excellent evaluations for speakers. It focused on promoting preconception health and providing care to diverse populations experiencing disparities. A panel of local experts providing advice on implementing preconception care was well received.

Planning is underway for the 3rd preconception conference focusing on reaching providers in rural Minnesota. With the current economic conditions of local communities, the conference will be a half day using interactive video capacity. One national speaker will present followed by a panel of local experts and opportunity for questions.

Title V staff continue to monitor births of VLBW infants according to "Guidelines for Perinatal Care" published by the American Academy of Pediatrics (AAP) and the American College of

Obstetricians and Gynecologists (ACOG).

MDH staff is part of the Preemie Network hosted by Children's Hospitals and Clinics of MN. Staff participates on a committee to explore using community health workers (under the supervision of a public health or home care nurse) follow up with families of preemies after discharge. This committee is addressing the disparity in preterm birth experienced by populations of color and how culturally sensitive care can improve their outcomes. In addition, carefully trained CHWs can educate mothers of preemies about reducing risk factors for having another preterm birth.

c. Plan for the Coming Year

Minnesota does not have Level III obstetrical and neonatal intensive care available throughout the state. This circumstance is not likely to improve. Title V staff, in partnership with the March of Dimes, continue to approach this issue educating providers and patients about risk factors for preterm low birth weight births and encouraging more timely referrals to Level III facilities when risk factors indicate that a very low birth weight delivery is possible.

Title V staff, others at MDH, and community partners will continue the activities stated above and explore opportunities to educate providers about the importance of high-risk deliveries occurring at an appropriate level facility. This will include providing information at the 3rd annual preconception care conference and other opportunities that may arise throughout the year.

Title V staff will meet with Rural Health and Primary Care staff at MDH to discuss partnering to continue to improve our trend of more VLBW deliveries occurring at Level III hospitals. It is planned that Title V staff will meet with rural hospital nursing directors to plan for more specific action steps.

Title V staff will present Minnesota data on this topic to the Maternity Case Management Excellence group in October 2009 to raise their awareness and seek their advice. It will be an ongoing topic with the Twin Cities Healthy Start staff.

Title V staff will continue to meet with the Preemie network and the CHW committee to work on reducing preterm births and improving preemie outcomes. In addition, MDH in collaboration with partners will continue to monitor the status of perinatal centers in Minnesota and the number and place of high-risk births. MDH staff and partners will also continue to promote the AAP/ACOG guidelines among providers.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	89.7	90.5	88	88	87
Annual Indicator	86.4	86.2	86.5	85.8	
Numerator	58410	58125	59928	60085	
Denominator	67633	67410	69281	70020	
Data Source					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	87	88	88	89	89

Notes - 2008
2008 natality data not yet available.

Notes - 2007
2007 data not yet available

Notes - 2006
The 2006 data are not yet available.

a. Last Year's Accomplishments
In 2007, 85.8 percent of infants were born to women receiving care beginning in the first trimester, representing a decrease from 86.5 percent in 2006. Minnesota has not yet achieved the Healthy People 2010 goal that 90 percent of births will occur to women who began prenatal care during the first trimester. Minnesota's average rates for women of color and American Indian women are farther beneath the Healthy People 2010 goal than that of White women.

Work continued with local health departments (LHD), representatives of health plans, and local providers to create a comprehensive, population-based model of prenatal care. Within this model, early identification of pregnancy, pregnancy intent, and early initiation of prenatal care is emphasized. Examples of initiatives to improve the number of women who initiate early prenatal care include the Twin Cities Healthy Start (TCHS) Program, the Nurse-Family Partnership initiatives in several Minnesota counties, and the Maternity Case Management Excellence (MCME) project in Minneapolis and St. Paul.

MCME meets semi-annually for education, resource sharing, and networking among providers, health plans and Title V staff. Activities included identifying gaps in services, implementing improvements and evaluating their effectiveness. MCME has created partnerships for service delivery as exemplified by the Perinatal Services Grid. This grid was created by the health plans to simplify service delivery for provider agencies. Health plans provided financial incentives to low income women on Medicaid prepaid health plans to access prenatal care in the first trimester and keep all scheduled appointments.

TCHS provided early identification of pregnancy, risk assessment, wrap-around support and education to high risk African American and American Indian women. They serve families until the infant is two years old, thereby providing interconceptional care and education about early prenatal care for the next pregnancy. LHDs, with Title V support, promoted the initiation of prenatal care in the first trimester. Some LHDs provided free pregnancy testing with referrals for appropriate services.

The Positive Alternatives Grant Program continued funding for grantee organizations that encourage and support women in carrying their pregnancies to term by providing a variety of services. Among these services is the requirement that all grantees provide information on, referral to, and assistance with accessing medical care. This includes encouraging and facilitating early access to prenatal care through early pregnancy testing, assistance in enrolling in state-funded medical programs, and prompt access to medical care.

Minnesota PRAMS data (2005) has identified women's barriers to obtaining early prenatal care. For mothers who did not get care as early as they wanted, the following barriers were identified: 21 percent of mothers stated they didn't have money or insurance to pay for prenatal care; 14 percent did not have their Medicaid or Minnesota Care card; 12 percent said they could not get an appointment earlier; 12 percent did not want anyone to know they were pregnant; 10 percent had too many things going on; and 5 percent said their doctor or health plan would not start care

earlier.

The American Indian Infant Mortality Review Project conducted in 2007 and reported in 2008 determined that of the 24 deaths reviewed, 11 mothers had early and adequate prenatal care (46%). The eleven mothers who were interviewed for the project cited some barriers to getting care early in their pregnancy. These barriers included not being able to get an earlier appointment, not getting time off work, and being too busy with other things to get early care. These findings have been disseminated and presented to a variety of audiences with the ability to educate and encourage American Indian women to get in for care early.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support activities that focus on primary health care, family planning, and medical homes for women				
2. Continue involvement on the Healthy Start grant				
3. Partner with racial & ethnic communities to identify and implement strategies for improving early prenatal care				
4. Continue partnerships related to community health worker Program				
5. Improve statewide universal and system capacity to provide perinatal mental health care.				
6. Continue TA to OMMH and their grantees on reducing infant mortality				
7. Sponsor Preconception Conference				
8.				
9.				
10.				

b. Current Activities

Outreach activities are fundamental to increasing the number of women who begin early prenatal care. LHDs maintain collaborative relationships with community organizations working with women of childbearing age. LHDs collaborate with health clinics, hospitals, extension services, social services, schools, Head Start and early childhood programs.

Title V staff continue to partner with state colleges and universities on their program for community health workers (CHW). CHWs will extend the reach of the health system to serve more people, particularly populations of color, immigrants, American Indians, and those at most risk for a late start to prenatal care. The 2007 Legislature approved Medicaid reimbursement for CHWs working under the supervision of a Medicaid-certified provider. Title V staff consults with Twin Cities Healthy Start and serves on the executive committee. The program focuses on improving rates of early and adequate prenatal care within high risk populations.

The second annual preconception conference focused on reaching underserved populations. The conference was attended by 138 persons from across the state and had several breakout sessions on culturally specific strategies to reach women of color, immigrants, and American Indians with education and interventions designed to assure all women are healthy throughout their reproductive years and plan and are ready for pregnancy. The need for early and adequate prenatal care for all populations was emphasized.

c. Plan for the Coming Year

Work will continue to address overarching issues leading to delays in prenatal care including pregnancy intendedness, family planning, preconception care, primary health care and

establishing a health care home. MDH will work collaboratively with communities to promote culturally appropriate education and awareness regarding the importance of early prenatal care and to address disparities in accessing early prenatal services.

The third preconception care conference is planned for October 2009. The conference will focus on reaching underserved populations in greater Minnesota and will bring attention to the need for providers to address women's health issues throughout the childbearing years.

Title V staff requested that the maternal and child health data epidemiology team put together geographic data for the state to determine where the highest rates of inadequate prenatal care are occurring. This data will be used by LHD, community agencies, and tribal health agencies to be better informed and reach out to women and providers in those specific areas. Race, ethnicity and age data as will be included. This will assure that specific strategies can be developed to get messages to those segments of the public most in need. Title V staff will also continue to review PRAMS data on barriers to accessing early prenatal care to further guide the strategies.

D. State Performance Measures

State Performance Measure 1: *Proportion of counties that universally offer the Follow-Along Program, or an equivalent approved tracking program, to all children birth to age three.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			53	65	0.7
Annual Indicator	0.3	0.5	0.6	0.6	0.6
Numerator	28	46	55	52	55
Denominator	87	87	87	87	87
Data Source					Follow - Along Program
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	0.8	0.8	0.8	0.8	0.8

Notes - 2008
Data souce: FAP Data Download from the local agencies: status as of 12/31/2008

Notes - 2006
In addition to the 55 counties, 1 tribal jurisdiction reported universally offering the Follow Along Program to its children.

a. Last Year's Accomplishments
The CYSHCN program has an interagency agreement with the Minnesota Department of Education for the child find or outreach activities pursuant to relevant provisions in Part C of the Individuals with Disabilities in Education Act (IDEA). Some of these responsibilities are carried out through the Follow Along Program (FAP). The FAP provides periodic screening and monitoring of those infants and toddlers at risk for health and developmental problems. It improves chances of identifying developmental problems at an early age, facilitates early intervention services for the child and links families and children to needed services. The FAP is supported programmatically and is funded through Title V and Part C of IDEA at the state level and a combination of Part C, Title V and local funds at the local level. The Ages and Stages
Questionnaire (ASQ) is the screening tool utilized by the FAP. The Ages and Stages Questionnaire (ASQ-SE) has been added to screening activities at local agency discretion over

the last four years. Ongoing training is provided to local agencies (primarily local public health agencies) on administration of and implementation of the FAP.

As of December of 2003, less than one-half of one percent (0.43 percent) of Minnesota infants birth to one were identified as eligible for early intervention services compared to 0.91percent nationwide; and only 1.43 percent of infants and toddlers birth to age three were identified as eligible compared to 2.23 percent nationally. Based (in part) on this data, the federal Office of Special Education Programs (OSEP) determined, in a 2005 program audit of IDEA in Minnesota, that the state is not implementing eligibility criteria consistent with Part C provisions or the state's approved Part C application for federal IDEA funds. The MCSHCN program worked with the Department of Education on changes necessary to meet federal requirements.

In 2005 the MDH Environmental Health Division ended a two-year, CDC-funded birth defects pilot study that focused on newborn infants with confirmed neural tube defects, cleft-lip/palate or chromosomal anomalies and began implementation of a more comprehensive birth defects information system that includes 44 identified conditions. In the pilot study, the CYSHCN program contacted identified families to provide health information and referrals to programs and services. This has subsequently expanded and continues that referral responsibility in the more comprehensive system. Infants born in the seven-county, Minneapolis-St. Paul Metropolitan Area with one of any of the 44 conditions are referred for follow-up. Families are then contacted to ensure appropriate referrals to services are made and families are also referred to either the Follow Along Program or Part C Early Intervention Services. Fact sheets for use by families and providers on each of the 44 conditions were completed in the summer of 2005.

Local agencies continue to expand the FAP by increasing the number of children screened for social-emotional or behavioral issues. Most of the children identified through the social emotional screening stay within local public health agencies, usually in the home visiting program, as these families need parental support rather than direct "mental health" services. Most are very young and have not yet started to display the severe behavioral symptoms of the older children.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide technical support to local public health agencies participating in the program.				X
2. Support advisory group to guide implementation of program enhancements				X
3. Integrate social emotional component into all screening programs			X	X
4. Convene regional FAP Coordinators Meetings				X
5. Analyze program data & disseminate written report			X	X
6. Provide statewide training on reimbursement & funding sources & effective screening, assessment & intervention			X	X
7. Train professionals including FAP coordinators and Human Services professionals on ASQ-SE				X
8. Collaborate and coordinate FAP activities with other state agency initiatives involving social-emotional screening of young children				X
9. Continue developmental and social-emotional screening of children 0-3 as an outcome measure for the Local Public Health Grant Activity.			X	X
10. Support Community Health Board use of federal Title V funds for this activity	X			

b. Current Activities

The CYSHCN program continues to provide technical assistance to local public health agencies through training sessions and software enhancements for the Follow Along Program. Children enrolled in the FAP as of December 31, 2007 totaled 30,502 children (23,640 Birth to 3 and 6862 3 to 5). The numbers have decreased due to a cut in funds to local public health agencies from local Part C funds and increased postage costs. More agencies are using their data for reports to community services on their activities in the FAP. One finding this year was discovered by accident. In an effort to reduce postage costs, agencies were inactivating families who had not returned developmental questionnaires. When informed of being dropped from the program, many families contacted the agencies with the request to stay on FAP. The families indicated that they were using the questionnaires with their child, but were not returning them because they did not have any concerns. Other agencies report that some families do not return the forms for several times but then they all come back when concerns are indicated. Many agencies continue to send the forms as anticipatory guidance for families and to stay connected with families in the event that the family does need to contact someone with a concern. Seventy percent (70%) of the local agencies offer the FAP to families regardless of risk factors. In addition, local public health departments provide direct services to over 4,600 very young CSHCN.

c. Plan for the Coming Year

A new and related priority - improve early identification and intervention for children birth to three - was identified in the most recent Title V needs assessment. Three specific areas of activity will contribute to early identification: The Follow-Along Program, the Birth Defects Information System and child find capacity building at the local level for early intervention services through Part C of IDEA. Current activities will continue and expand. The BDIS will expand from surveilling births in the seven-county, Minneapolis-St. Paul Metropolitan area to all births in the state. Technical assistance and training will be provided to Follow-Along Programs. The FAP software will be upgraded to include the capacity to email families with internet access to reduce postage costs. Work continues on encouraging 2 of the non participating counties to reinstitute the FAP. It is anticipated that child find materials will be modified to the extent that the results of the evaluation indicates with increased efforts to provide culturally and linguistically appropriate materials.

Work with interagency partners continues to increase the percentage of young children who receive early intervention services. A particular focus has been participating in evaluating various screening tools for use by local agencies that can be used to identify children who may have a developmental delay. Trainings have been provided to local agencies (public health,education, social services, Headstart, child care on the correct use and interpretation of the ASQ and the ASQ-SE). Improving early identification and intervention for children birth to three is the priority this performance measure addresses. However, this single performance measure provides a limited picture of the multiple efforts directed toward this priority.

State Performance Measure 2: *Percent of children enrolled in Medicaid who receive Early Periodic Screening, Diagnosis, and Treatment (EPSDT), also known as Child & Teen Checkup (CTC) in MN.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			64	65	66
Annual Indicator	62.3	63.8	63.8	65.5	68.1
Numerator	156113	161179	161179	165652	176401
Denominator	250456	252584	252584	253051	258938

Data Source					DHS
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	69	69	70	70	72

Notes - 2007
2007 data is not yet available

Notes - 2006
Data is being corrected from data entry error in previous years. Data presented for 2005 should be for 2006.

a. Last Year's Accomplishments
The Title XIX EPSDT program in Minnesota is called Child and Teen Checkups (C&TC). The percent of C&TC eligible infants, children and adolescents who received at least one preventive health visit was 68.1% in 2008 compared with 65.5% in 2007. This represents an increase in number of children receiving EPSDT services in the past year and exceeds our projected annual performance objective for 2008 by 2%.

Under contract with the Department of Human Services (DHS), Title V staff offered an extensive schedule of C&TC trainings on best practices in well child health screening exams to health care providers. Participants included public health nurses, school nurses, private providers, C&TC outreach coordinators, managed care health plan representatives, and other child health screeners. On-site follow-up consultations by Title V staff (pediatric nurse practitioners) were conducted for public health nurses newly trained to provide C&TC screening services.

Several workshops were developed for C&TC providers through the efforts of local C&TC Coordinators, the DHS, managed care health plans, and Title V staff. The workshops were presented at various sites throughout the state and provided a general overview of C&TC including: 1) best practice standards for hearing and vision screening; 2) practical methods to incorporate developmental and social-emotional screening into a busy practice; and 3) detailed billing information to ensure appropriate and complete reimbursement for C&TC.

Title V Staff continue to contribute to the expansion of the Minnesota ParentsKnow website (http://www.parentsknow.state.mn.us/). The website was developed specifically for parents to provide up-to-date, research-based information on child growth and development from birth through grade 12.

Title V staff collaborated with DHS and Women, Infants and Children (WIC) to develop a 2008 C&TC/WIC family recipe book. The recipe book will be used as an outreach tool for families in the WIC program and contains nutritional recipes and developmental milestones, as well as information about both programs.

The Interagency Developmental Screening Task Force sponsored trainings for several recommended screening instruments such as the Brigance, ESI-R, IDI/CDR-PQ, and the ASQ/SE which were captured on videotape and posted to the MDH/C&TC website in 2008 (www.health.state.mn.us/divs/fh/mch/devscrn). Additionally, the interagency partnership between the Title V program, DHS, the Department of Education, University of Minnesota, and the Minnesota Head Start provided updates to the statewide recommended pediatric developmental and social-emotional screening instruments list.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Continue to provide education, training, and technical assistance on the multiple components of C&TC as a joint activity with DHS				X
2. Develop, implement and promote quality improvement initiatives for child health in partnership with public and private organizations focused on pediatric health care			X	X
3. Maintain and enhance partnerships with other organizations that are working to assure optimal child and adolescent health care		X	X	X
4. Assess the needs of public and private providers of C&TC screening services and provide training, education, and technical assistance around identified needs		X	X	X
5. Promote evidence-based best practices in child and adolescent health care.		X	X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Title V staff continue to collaborate with DHS on the C&TC program. Staff provide technical support to C&TC providers and outreach coordinators to increase participation and training on pediatric preventive health services.

Title V staff partnered with the MN Chapter of AAP and DHS to implement the MN Child Health Improvement Partnership's (MnCHIP) first quality improvement project. The purpose was to assist primary care clinics to integrate standardized developmental, mental health, and maternal depression screening into C&TC well child exams. Plans are being developed to spread the results to other primary care clinics.

Through a partnership with Gillette Children's Specialty Healthcare, Shriner's Hospital for Children, primary care providers, orthopedic specialists, school nurses and other stakeholders, Title V staff revised the Scoliosis School Screening Recommendations www.health.state.mn.us/divs/fh/mch/scoliosis/index.html.

An online needs assessment was conducted by Title V staff to identify training needs of C&TC providers. The results of this survey will be used to plan the next fiscal year's C&TC trainings and develop curriculum for an upcoming adolescent health training.

Title V staff are conducting a pilot project to improve lead screening through the use of a brochure targeted to parents. The MDH Lead Project was tested in 2008 with 8 LHDs. Evaluation is being finalized and will compare blood lead level rates before and after the introduction of the brochure.

c. Plan for the Coming Year
The Title V staff will continue to review and evaluate current literature as well as information in respected publications such as Bright Futures to develop recommendations for health supervision of infants, children, and adolescents that reflect current evidenced-based practice. Currently, staff are working with DHS to update the state's well child screening exam periodicity schedule, as well as the corresponding fact sheets http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-3379-ENG.

Title V staff serve on the MnCHIP advisory group and will continue to provide technical assistance and consultation to C&TC primary care providers as needed on future improvement

projects.

The Title V staff will be revising their online C&TC training modules for the following topics: Hearing Screening, Vision Screening, Developmental and Social-Emotional Screening, Oral-Dental Health Screening, Lead Screening, and Introduction to EPSDT.

Curriculum is currently being developed for two upcoming trainings: Adolescent Health and Developmental and Mental Health Screening (i.e. use of standardized screening instruments and referral linkages). These trainings are being designed to meet the needs of C&TC providers across the state and will involve a variety of learning experiences.

State Performance Measure 3: *Percent of sexually active ninth grade students who used a condom at last intercourse.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			70	71	71
Annual Indicator	69	69	69	70.8	70.8
Numerator				5642	5642
Denominator				7971	7971
Data Source					MN Student Survey
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	71	74	74	74	74

Notes - 2008
Minnesota Student Survey is data source for this Performance Measure. It is conducted every 3 y ears. Next survey is scheduled for 2010.

Notes - 2006
Data from the 2004 MN Student Survey were applied again to this year.

a. Last Year's Accomplishments
Minnesota used a total of $10.78 million in state and federal funds to support the Family Planning Special Projects (FPSP) grant program over two years beginning July 1, 2007. This includes financial support for all method services (including condoms), as well as outreach and education to community groups and juvenile detention sites. Local health departments (LHD) continue to use federal Title V funds to provide family planning method services, reproductive counseling services, and health education in schools.

Forty grantees of the FPSP grant program continued to receive money in the second year of the two year grant cycle which ends June 30, 2009. The total awarded for Year 2 was $5.43 million. One of those grantees is a family planning and sexually transmitted infection hotline (Hotline). The Hotline is staffed by individuals trained in information and referral as well as family planning and STI counseling. Over 2,800 calls were handled by the Hotline from July 2007 through June 30, 2008. Thirty-three percent (8,900) of the clients receiving counseling services through FPSP and thirty-five percent (7,481) of the clients receiving family planning methods were 14-19 years of age. There were 1,303 male clients receiving family planning methods through FPSP.

The Medicaid 1115 Waiver program, Minnesota Family Planning Program (MFPP) completed its second year. It continues to serve around 28,000 individuals per year. Under MFPP, adolescents (15 years of age and above) are eligible for family planning services, including condoms.

The Minnesota Education Now and Babies Later (MNENABL) program funded a service-learning

training for professionals implementing the Teen Outreach Program (TOP) in order to enhance their current programming. This was done in collaboration with the Minnesota Organization on Adolescent Pregnancy Prevention and Parenting (MOAPPP). In 2008 the state legislature eliminated MNENABL grant funding. However, funding was retained to support a .5 FTE adolescent health coordinator.

The MDH adolescent health coordinator worked with the Minnesota Department of Education to increase collaboration and joint efforts directed at STI/HIV prevention. The two departments supported the replication of an evidence based intervention to address the STI epidemic in Minnesota's Alternative Learning Centers (ALCs). The intervention would take place during summer session and target high risk students from Minneapolis and St. Paul ALCs.

The state adolescent health coordinator served as faculty for the University of Minnesota's Summer Institute in Adolescent Health in collaboration with the Konopka Institute for Best Practices in Adolescent Health, the School of Nursing, & MOAPPP. The Summer Institute brought in nationally recognized experts on adolescent sexual health for professionals working in the field. Participants found it highly valuable, and learned many new skills to apply to their work addressing the sexual health needs of MN youth. The Coordinator also served on the planning committee for MOAPPP's yearly conference.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to support Minnesota Student Survey data collection and analysis				X
2. Support access to family planning services for sexually active youth	X	X	X	
3. Increase public understanding of social, economic and public health burdens of unintended pregnancy			X	X
4. Support school based clinics and advocate for comprehensive sexuality education	X		X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

FPSP and the Title V continue to support reproductive health services including contraception services and outreach. The STD/HIV prevention intervention in a metro alternative learning center had staffing setbacks, but should take place in the next school year.

The adolescent health coordinator was trained as a TOP trainer, one of the first group of certified trainers outside of the Wyman Center in St Louis, MO to participate in the program's replication. TOP trainings are continuing statewide in collaboration with MOAPPP.

The 2007 Minnesota Student Survey data continues to be analyzed. The state adolescent health coordinator co-authored a comprehensive report of sexual health data in Minnesota in collaboration with the Department of Education and Public Safety, which included a section on condom use and condom education in Minnesota's public schools.

The adolescent health coordinator received a grant through AMCHP and NACCHO for Teen Pregnancy and STD/HIV Prevention to work collaboratively with the Department of Education, a

LHD, the local teen pregnancy prevention coalition, and MOAPPP, to address high rates of STDs and teen pregnancies in rural Worthington, MN. A presentation on best practices and media approaches to address sexual health was given in March to Worthington's teen pregnancy prevention coalition, and more technical assistance planning is underway. Activities will be completed by 9/30/09.

c. Plan for the Coming Year
The next cycle of FPSP grant awards will begin July 1, 2009. Staff will continue to help promote the 1115 Medicaid waiver and support family planning service providers in using the waiver.

As a TOP trainer, staff will continue to train professionals in TOP and assist in technical assistance. The ALC STD/HIV Prevention Intervention will be completed and evaluated. Staff will continue to work collaboratively with others within and outside the Department to help address the sexual health needs of adolescents.

State Performance Measure 4: *Incidence of determined cases of child maltreatment by persons responsible for a child's care.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			6.1	6	5
Annual Indicator	6.0	6.2	5.4	4.9	
Numerator	7784	7983	6998	6227	
Denominator	1286894	1286894	1286594	1259456	
Data Source					
Is the Data Provisional or Final?				Final	
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	4.5	4.5	4	4	4

Notes - 2008
2008 data not yet available.

Notes - 2007
2007 data not yet available

Notes - 2006
The 2006 data are not yet available.

a. Last Year's Accomplishments
The 2007 Legislature amended the Family Home Visiting (FHV) statute and increased Temporary Assistance for Needy Families (TANF) funding to local health departments (LHD) and tribal governments to support home visiting services for families with identified risk factors including risk for child maltreatment. The MDH convened FHV Steering, Training, and Evaluation Work Groups to advise on the implementation of the 2007 FHV statute.

In March, 2008, LHDs and tribal governments submitted detailed plans describing their approach to provide home visiting services to pregnant and parenting families. Adolescents, families with a history of alcohol and chemical use and families with a history of child maltreatment and family violence were the high risk families most frequently targeted by LHDs to receive home visiting services. The FHV Training Work Group developed a training and implementation plan based on best practices for preparing home visitors to provide quality home visiting services to high risk families. The FHV Evaluation Work Group developed a plan for identification of measurable outcomes for the program. Examples of outcome measures recommended in the 2007 statute

included rates of substantiated child abuse and neglect and rates of unintentional child injuries.

In April 2008, staff partnered with Prevent Child Abuse Minnesota (PCAMN) to plan and co-sponsor PCAMN's annual conference and interactive videoconference trainings for LHDs and community partners to promote April as Child Abuse Prevention Month. In April 2008, staff also collaborated with the SID Center to sponsor a training for LHD and newborn nursery staff. The goals were to discuss data on sudden unexpected infant deaths and current recommendations for safe infant sleep practices to assure parents receive consistent evidenced-based messages regarding safe infant sleep environments.

In May and June 2008, staff sponsored two trainings for PHNs and family home visitors on a curriculum developed by NCAST-AVENUW titled "Promoting First Relationships" (PFR). PFR is a guide for PHNs and home visitors to assist parents and other caregivers to meet the social and emotional needs of young children. Over 50 PHNs and home visitors attended the PFR trainings.

Staff participated on the Department of Human Services' (DHS) Child Mortality Review Panel. The state panel reviews clusters of similar deaths of children and makes recommendations for systems changes to protect children.

Staff coordinated two NCAST-AVENUW Parent Child Interaction (PCI) trainings and supported the use of the PCI tools by trained local and tribal public health nurses

In 2008, a FHV consultant was trained on the Nurse-Family Partnership (NFP) home visiting model. One of the goals of the NFP model is to improve child health and development and reduce child maltreatment by helping parents provide responsible and competent care. There are five NFP projects in Minnesota implemented in seventeen counties. FHV staff support the NFP projects to maintain model fidelity.

Minnesota continued the "Safe and Asleep in a Crib of their Own" campaign in partnership with the Minnesota SID Center. Posters, flyers and brochures consistent with the American Academy of Pediatrics infant sleep guidelines (November 2005) were disseminated across the state to local health departments, tribal health, community organizations, child care providers, hospitals, and clinics. The brochure is available in English, Spanish, Hmong, and Somali.

MDH and SID Center staff presented "Safe and Asleep" information at conferences through presentations and exhibits. Family home visiting staff distributed information and materials in their trainings and meetings.

Minnesota legislation to reduce the incidence of abusive head trauma to infants (Shaken Baby Syndrome) requires birthing hospitals to educate parents of newborns on definitions and prevention strategies before the baby leaves the hospital. To enhance this parent education, MCH staff distributed "Babies Cry" cards to local public health, tribal health, and community agencies with a suggested parent education protocol to further remind parents and other caregivers of newborns how to safely manage inconsolable crying of young infants. The cards are available in English, Spanish, Hmong and Somali.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Identify and participate in opportunities to provide surveillance, identify and disseminate best practices and develop policies to reduce maltreatment.				X
2. Continue involvement Child Death Review Panels				X
3. Develop/update and distribute Infant Death Investigation Guidelines			X	X

4. Disseminate strategies for prevention of child maltreatment i.e., home visiting		X		X
5. Continue to provide NCAST training			X	X
6. Continue to educate parents & other caregivers on prevention of abusive head trauma (Shaken Baby Syndrome)				X
7. Continue to promote education of parents & other caregivers on Safe Infant Sleep		X		
8.				
9.				
10.				

b. Current Activities
FHV staff provide support for best practices for home visitors to at risk pregnant and parenting families. Staff coordinated four NCAST-AVENUW PCI trainings. Two family home visiting consultants are available to provide PCI training.

The FHV team received an ACF grant to support evidence-based home visiting to prevent child maltreatment. The goal is to enhance, expand and sustain evidence-based home visiting programs by supporting infrastructure development and the implementation of the NFP model among population groups experiencing health disparities.

The FHV Evaluation Plan identifies measurable outcomes for the FHV program including an indicator on the incidence of child maltreatment. A statewide feasibility study for measurement of these outcomes is being conducted 1/1 through 6/30/09.

Dissemination of "Safe and Asleep Campaign" materials and presentations are offered to including doulas, Positive Alternatives grantees, breastfeeding coalitions, and American Indian men. MCH staff provide support and consultation to a Twin Cities Healthy Start safe infant sleep project with culturally specific materials addressing the higher rates of sleep-related deaths and SIDS among African American and American Indian infants.

Following the completion of Minnesota's American Indian Infant Mortality Review Project, MCH staff is providing technical assistance to the Community Action Team implementing project recommendations around safe infant sleep in the American Indian population.

c. Plan for the Coming Year
MDH will maintain a partnership with the SID Center as a key component of efforts to reduce infant mortality. The SID Center provides grief support to families and providers and provides risk reduction interventions education. The SID Center maintains communication with coroners and medical examiners and encourages use of MN Infant Death Investigation Guidelines to improve diagnosis of sudden unexpected infant deaths.

Increasing numbers of infant deaths have occurred as unintentional injuries related to unsafe infant sleep conditions. Title V staff continue to collaborate with the SID Center to distribute infant sleep safety materials on bedding, cribs, the Safe Sleep Top Ten, tummy time, and information for grandparents. MDH plans to reach 10,000 to 20,000 families or caregivers in the coming year.

FHV will continue to coordinate NCAST-AVENUW PCI trainings and support the use of the PCI scales by trained and reliable county and tribal public health nurses.

Title V staff will continue to participate on the DHS Child Mortality Review Panel. The panel reviews clusters of similar deaths and makes recommendations for systems changes.

FHV staff plan to implement the FHV training and evaluation plans and provide support to family health supervisors, MCH and home visiting staff in LHDs and tribal governments in MCH, home

visiting, reflective supervision, motivational interviewing, relationship based practice, and comprehensive assessment and care planning. Activities related to these priorities continue to evolve. The FHV website will be maintained and updated with training resources, home visiting strategies and best practices, home safety resources, shaken baby syndrome prevention materials, infant sleep safety and postpartum depression educational materials and home visiting guidelines.

Staff will implement the plan to enhance, expand and sustain evidence-based home visiting programs in Minnesota by supporting infrastructure development and the implementation of the NFP model among a population group(s) experiencing health disparities that has not previously been part of the NFP randomized trials. FHV staff will provide consultation and support to Minnesota's NFP home visiting projects to maintain model fidelity.

Staff plan to continue promoting the prevention of abusive head trauma (Shaken Baby Syndrome) to infants and the "Safe and Asleep Campaign" as resources allow. Promoting Safe Infant Sleep has been identified as a key activity in reducing the infant mortality racial and ethnic disparity experienced by Minnesota's African American and American Indian families.

Information and materials will be distributed to each agency regarding "The Happiest Baby" educator certificate program. It is anticipated that each LHD and tribal agency will have one certified educator and that information will be provide on home visits or group sessions regarding how to calm a crying infant. This will support local efforts to prevent Shaken Baby Syndrome.

State Performance Measure 5: *Percent of pregnancies that are intended.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			70	71	65
Annual Indicator	64.4	66.3	64.0	63.7	
Numerator	42153	44408	43882	44066	
Denominator	65501	67017	68538	69230	
Data Source					
Is the Data Provisional or Final?				Final	
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	66	66	67	67	67

Notes - 2008
2008 PRAMS data not yet available.

Notes - 2007
2007 data not yet available

Notes - 2006
PRAMS data for 2006 are not yet available.

a. Last Year's Accomplishments
According to the Minnesota Pregnancy Risk Assessment Monitoring System (PRAMS) survey done with 1580 Minnesota mothers who had a baby in 2007, the percent of pregnancies that are intended in Minnesota have remained essentially the same from 2006 to 2007. The data are more concerning when looking at pregnancy intendedness for specific demographic groups. For example, while 81% of mothers age 35+ intended pregnancy, only 23.7% of mothers less than age 20 intended pregnancy. Of mothers with a college education, 79.5% intended pregnancy, while only 47% of mothers with a less than high school education and 50.6% of mothers with a high school education intended pregnancy. The self-reported income of mothers also differed

greatly. While 38% of mothers with incomes below $14,999 intended pregnancy, 80.2% of mothers within income above $50,000 intended pregnancy.

Minnesota uses state and federal TANF funding to support Family Planning Special Projects grants (FPSP). FPSP funds are used by local communities to provide method services, as well as outreach and education to those at risk for unintended pregnancy. Local health departments (LHD) use federal Title V funds to provide family planning method services, reproductive counseling services, and health education in schools.

A total of $10.78 million dollars in FPSP grants were awarded over two years beginning July 1, 2007 to 40 programs representing all regions of the state, as well as a Family Planning and STI Hotline. $1.15 million per year of this total is received from Temporary Assistance for Needy Families (TANF) funds. The Medicaid 1115 Waiver program, Minnesota Family Planning Program (MFPP) completed its second year. It continues to serve approximately 28,000 individuals.

The first annual Preconception Care Conference was held on October 5, 2007, with approximately 150 participants. One of the primary goals of the conference was to facilitate the inclusion of preconception care into current standard delivery systems. Based upon pre and post test data, the percent of conference participants indicating the goal was attainable increased from 74 percent to 80 percent while those who were "unsure" decreased from 25 percent to 14 percent.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Analyze PRAMS data				X
2. Ensure efficient and effective use of state funds for family planning services.	X	X	X	
3. Partner with Department of Human Services to successfully implement 1115 Family Planning Waiver.			X	X
4. Increase public understanding and support for policies & programs that reduce unintended pregnancies			X	X
5. Consider policy and program recommendations for prenatal, interconception care and child spacing.			X	X
6. Continue to direct resources to a hotline for family planning and STI services			X	X
7. Support school-based clinics and comprehensive reproductive health education.			X	X
8.				
9.				
10.				

b. Current Activities

MDH staff conducted site visits with all 40 grantees during 2008 to monitor their progress and provide technical assistance. Staff sends a monthly newsletter with news of trainings and the latest research on family planning to all grantees. A new request for proposal for the two-year grant cycle beginning July 1, 2009 was posted in January 2009. Forty nine applications were received. Award announcements are expected to be made by June 2009. MDH continues to work with DHS to promote the 1115 Medicaid Waiver and assist FPSP grantees in implementation of MFPP in their clinics.

There were 138 attendees at the second annual Preconception Care Conference who heard both national and local speakers discuss specific issues and strategies addressing preconception care for underserved populations. The conference was well received according to evaluation data.

Especially favorably received was a panel of local experts who made brief presentations and took questions from the audience with practical advice on implementing preconception care within their existing programs. Breakout session topics included reaching African Americans, Somalis, American Indians, women in rural Minnesota, Hmong women, and a viewing and discussion of "When the Bough Breaks".

PRAMS, BRFSS, Minnesota Student Survey and Abortion Report data will continue to be analyzed to provide information on possible strategies for improving pregnancy intendedness.

c. Plan for the Coming Year
The next cycle of FPSP grant awards will begin July 1, 2009. Staff will continue to help promote the 1115 Medicaid waiver and support family planning service providers in using the waiver.

Planning is underway for the 3rd annual preconception conference to be held in October 2009 with a focus on reaching health care providers and local public health in greater Minnesota. Acknowledging the current economic conditions of local communities, including limited budgets for travel and expenses and limits to staff's ability to be away from their work, the plan is to have a half day conference using the MDH's statewide interactive video capacity. One national speaker will present followed by a panel of local experts and extensive opportunity for questions and answers from the audience.

State Performance Measure 6: *Percent of pregnant women screened for depression during routine prenatal care.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			83	84	86
Annual Indicator	82.1	85.4	85.6	88.9	
Numerator	54466	56690	59389	61744	
Denominator	66369	66396	69413	69422	
Data Source					
Is the Data Provisional or Final?				Final	
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	86	87	88	88	88

Notes - 2008
2008 PRAMS data not yet available.

Notes - 2007
2007 data not yet available

Notes - 2006
The 2006 data are not yet available.

a. Last Year's Accomplishments
Postpartum depression education legislation was passed in 2005 that requires hospitals to provide new parents and other family members written information about postpartum depression (M.S.145.906). A work group, the Postpartum Depression Education Work Group, representing a broad range of health care providers, consumers, mental health advocates and families was brought together to develop educational materials and to recommend policies and procedures for the implementation of the legislation. The brochure and fact sheet are now available in five languages: English, Hmong, Russian, Somali, and Spanish. These materials were made available to attendees at the Minnesota State Fair in August 2008 as part of the MDH booth

which focused on maternal and child health. These materials are available on the MDH website at: http://www.health.state.mn.us/divs/fh/mch/fhv/strategies/ppd/index.html.

The Postpartum Depression Education Work Group continued to meet in 2007 in order to share knowledge of resources related to perinatal depression, discuss systems issues related to screening and treatment, and develop and refine a PowerPoint presentation on perinatal depression which can be adapted for various audiences. With the initial work of this group completed, meetings were not held in 2008. Multiple presentations, exhibits and materials were provided on maternal mental health and postpartum depression in a variety of venues. Examples include statewide conferences, workshops and community events, such as the 2007 Minnesota Community Health Worker Conference, the National Alliance for the Mentally Ill-Minnesota (NAMI-Minnesota) conference and Healthy Development Conference.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Promote maternal depression screening by providers during routine prenatal and postpartum visits as well as during pediatric and well child visits			X	
2. Update/translate (as needed) and disseminate maternal depression education materials to prenatal, hospital, postpartum, and pediatric/well child practitioners		X		
3. Provide technical assistance and educational opportunities for county and tribal health staff on maternal mental health promotion, risk/protective factors, screening and referral, and issues related to working with women with mental illness				X
4. Provide education through appropriate media to health consumers and the public on maternal mental health and the importance to the health and well being of the mother and her family.		X		
5. Provide leadership and collaborate with other state agencies and providers, health plans, and others regarding the need to address appropriate mental health services for prenatal and postpartum depression.				X
6. Promote and monitor reimbursement for prenatal and postpartum depression screening by the Department of Human Services and Minnesota Health plans.				X
7.				
8.				
9.				
10.				

b. Current Activities

Pregnancy Risk Assessment Monitoring System (PRAMS) data is being analyzed by program staff. Between 2002 and 2007, the percentage of women reporting that a doctor, nurse, or other health care worker talked with them about "baby blues" or postpartum depression during their pregnancy or after delivery has increased in a significant linear trend (2002: 76.87%; 2003: 82.50%; 2004: 82.06%; 2005: 85.38%; 2006: 85.56%, 2007: 88.9%). In coordination with the CHC, the PRAMS questionnaire was revised for births beginning in 2009. Revisions include the addition of questions which will gather data regarding risk factors associated with postpartum depression.

Planning for a 2009 National Alliance on Mental Illness (NAMI)-Minnesota conference on postpartum depression is underway. MDH are involved in the planning process.

The Great Start Minnesota project continues to promote screening for maternal depression in pediatric clinic settings.

The Postpartum Depression Education Work Group meets periodically on an as needed basis. Work Group members continue to share information about resources and assisted in the development of a statewide resource list. This work was done in collaboration with Pregnancy and Postpartum Support Minnesota (PPSM), Minnesota's local chapter of Postpartum Support International. A link to this list is posted on the MDH web site and coordination continues to maintain up to date information.

c. Plan for the Coming Year
Analysis of Minnesota's PRAMS data on postpartum depression will continue. Data continue to be analyzed and shared to raise awareness of the need to screen for perinatal depression. Data from the revised PRAMS questionnaire will be available mid year 2011.

MDH will continue to work with Pregnancy and Post Partum Support Minnesota to further develop a speaker's bureau and promote training for mental health practitioners to increase the availability of clinical intervention for postpartum depression and other perinatal mood disorders. Training on postpartum depression screen will be offered for home visitors throughout Minnesota in conjunction with MDH's Comprehensive Assessment training for the Family Home Visiting Program.

Information regarding screening for postpartum depression will be routinely provided to pediatric and family practitioners through MDH Child & Teen Check-ups (EPSDT) 3-day and newborn/preemie trainings.

MDH staff will continue monitor funding opportunities to support education regarding postpartum depression and advance perinatal depression screening and treatment services.

MDH will continue to provide leadership, technical assistance, and training opportunities with community partners, local health department and tribal health staff, and others regarding the importance of perinatal depression screening and the need to address system issues that limit access to timely and appropriate mental health services for perinatal depression.

State Performance Measure 7: *The degree to which Title V programs enhance statewide capacity for a public health approach to mental health promotion and suicide prevention for children and adolescents.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			2	2	2
Annual Indicator	0	1	1	2	2
Numerator	0	1	1	2	2
Denominator	4	4	4	4	4
Data Source					MCSHN
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	3	3	4	4	4

a. Last Year's Accomplishments
Five suicide prevention grants were awarded to local, community-based agencies. Four of these grantees included prevention activities targeting children and youth, and the fifth grantee focused

on adults over the age of 55. These grants combined funding from a state general fund appropriation for suicide prevention, federal mental health block grant funding and state funds from the MCSHN program. A limitation on the use of the federal funds is the reason why one of the grantees' target population was adults over 55. The Minnesota Department of Human Services administers the SAMHSA mental health block grant and the decision to combine federal and state funds for suicide prevention and have Title V manage the grants reflects the positive collaborative working relationship between the two programs.

The suicide prevention and mental health promotion program was relocated to the Title V-CSHCN unit and new staff hired in September of 2008. Staff worked with the Mental Health Workgroup of the Maternal and Child Health Task Force to develop recommendations that build on a public health approach to children's mental health. This began in the summer of 2008 and concluded in December. Examples of recommendations include: a) promotion of healthy behaviors through support of a public health model of mental health, b) collaboration with partners to promote mental health and prevent mental illness, and c) strengthen capacity to support mental health promotion and wellness. Each recommendation is accompanied by suggested strategies.

Staff also participated on the department of human service's State Advisory Council on Mental Health and its Subcommittee on Children's Mental Health. MCHSN staff also met regularly with other state agencies that address mental health and the social and emotional development of children and youth, including the department of education, and the department of corrections. Staff continued to work closely with statewide Tribal Health Directors and with the tribal liaison at the MDH Office of Minority and Multicultural Health.

Staff provides technical assistance to local public health and community organizations on mental health and suicide prevention, including surveillance data, information about evidence-based strategies, and resource information. Several trainings were again held around infant mental health, with both general education and skill development and training specific to the DC: 0-3 classification of infant diagnostic coding that supports treatment and reimbursement.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Review and update, with key stakeholders, the State Suicide Prevention Plan				X
2. Continue to provide trainings around suicide prevention and children's mental health issues				X
3. Continue to partner with DHS (mental health authority) related to mental health screening, intervention and treatment				X
4. Design and implement a suicide prevention program in response to state legislation			X	X
5. Represent MDH on State Advisory Council on Mental Health and children's mental health subcommittees and related mental health workgroups				X
6. Partner with the Departments of Education and Human Services on annual statewide mental health conference				X
7. Administer suicide prevention grants	X			X
8. Continue to partner with the Department of Human Services related to suicide prevention strategies and suicide response.			X	X
9.				
10.				

b. Current Activities

Staff continues to manage suicide prevention grants and provide technical assistance, training and consultation to suicide prevention grantees, as well as technical assistance and consultation to local agencies and organizations including surveillance data, information on evidence-based strategies and resource information. MDH submitted a grant proposal for the Garrett Lee Smith suicide prevention funding awarded annually by SAMHSA.

Several presentations were conducted for internal and external audiences related to mental health and suicide prevention. Staff recently collaborated with the University of Minnesota to help plan the 2009 Summer Institute in Adolescent Health, which will focus on social and emotional health. In March, MDH held one-day training for suicide prevention grantees and tribal health, mental health, and education staff. Dr. Theresa LaFromboise presented a workshop on an evidence-based, culturally-specific prevention curriculum she developed called the American Indian Life Skills Development. This curriculum covers a broad range of topics and life skills, including substance use, suicide, coping with trauma, healthy problem-solving and decision-making, and how to help a friend.

Program staff continues to participate on the State Advisory Council on Mental Health and the Subcommittee on Children's Mental Health. MDH continues activities noted above with the mental health work group, supporting or providing trainings as resources are available.

c. Plan for the Coming Year

Title V staff will continue management of the grants awarded for suicide prevention. Title V also plans to continue providing state grants to local agencies and organizations with an increased emphasis on evidence-based mental health promotion and suicide prevention practices. Program staff will continue to provide technical assistance and consultation, surveillance data, and information about resources and best practices to local organizations and the general public. Staff will also continue to meet with other state agencies on a regular basis around children's mental health and suicide prevention, and will continue to be involved with the State Advisory Council on Mental Health and its Subcommittee on Children's Mental Health.

MDH will continue to provide technical assistance to local public health and community organizations on mental health and suicide prevention and staff will continue activities to assist in the implementation of the recommended strategies from the mental health work group of the MCH Task Force through supporting or providing trainings as resources are available. MDH will work with local public health agencies to: (1) determine the additional capacity and training needs of LPH nurses, health educators and other local staff regarding mental health promotion and suicide prevention; and (2) support development of needed resources and capacity for our LPH constituents statewide.

State Performance Measure 8: *The ratio of the low birth weight (<2500 grams) rate for American Indian women and women of color to the low birth rate for white women.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			1.2	1.2	1.1
Annual Indicator	1.3	1.4	1.3	1.4	
Numerator	80.9	86	82	8.5	
Denominator	60.6	60.1	61	6.2	
Data Source					
Is the Data Provisional or Final?				Final	
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	1	1	1	1	1

Notes - 2008
2008 natality data not yet availab.e

Notes - 2007
2007 data not yet available

Notes - 2006
The 2006 data are not yet available.

a. Last Year's Accomplishments
Title V staff provided consultation and resources to community-based programs that address racial/ethnic disparities in birth outcomes, including infant mortality and low birth weight.

The federally funded Twin Cities Healthy Start (TCHS) program provided outreach, case management and health education to African American and American Indian pregnant and parenting families in Minneapolis and St. Paul. The TCHS program focused on reducing disparities in infant mortality and reducing LBW, especially among African American infants. Low birth weight rates among African American infants are more than twice the rate of White infants (8.7% vs. 4.3% for the years 2003-2007). TCHS staff attended the smoking cessation in pregnancy and reducing adolescent substance abuse workshop presented by Title V and tobacco section staff in partnership with a metro health plan and TCHS in June 2008. TCHS programs used the cessation resources available from MDH. Smoking cessation in pregnancy is a strategy to reduce low birth weight.

Recognizing that disparities in LBW are related to the availability of culturally competent health care services, Title V staff continued to support Community Health Worker (CHW) education and employment. Legislation in 2007 allowed for Medicaid reimbursement for CHW services when provided under the supervision of a Medicaid-enrolled provider. CHWs are recognized as valuable community providers who can bridge a gap between health care providers and populations of color. Connecting women to health care and other resources such as WIC in pregnancy can help reduce LBW.

Title V staff provided consultation and resources to programs funded by the MDH's Office of Minority and Multicultural Health's Eliminate Health Disparities Initiative. This funding included support for reducing infant mortality and LBW disparities between Whites and populations of color. The funded programs provided a variety of services including doulas, health education, smoking cessation, child spacing and support for breastfeeding. All services addressed reducing the disparity in infant mortality and reducing low birth weight.

The American Indian Infant Mortality Review Project conducted in 2007 and reported in 2008 determined that of 24 deaths reviewed, 9 babies were born at low birth weight (38%). Although this is not surprising in a population of babies who died, it is a reminder that reducing LBW is also a priority among the American Indian population. Strategies to accomplish this are underway including: encouraging preconception care and early prenatal care among American Indian populations, smoking cessation during pregnancy and prevention of postpartum relapse, and encouraging all eligible pregnant women to enroll in the WIC program.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Ongoing collaboration with Twin Cities Healthy Start		X	X	X
2. Ongoing partnership with MN State Colleges on Community Health Worker education project		X	X	X
3. Ongoing technical assistance to the Eliminate Health			X	X

Disparities Initiative, infant mortality grantees				
4. Continue to dialogue with Tribal Health Leaders around issues related to poor pregnancy outcomes.		X	X	
5. Continue to provide TA to Tribal Governments on Family Home Visiting			X	X
6. Continue efforts to inform the public of the need to stop smoking and engaging in other high risk activities during pregnancy.			X	X
7.				
8.				
9.				
10.				

b. Current Activities
MDH and other partners from the American Indian Infant Mortality Review project are collaborating on a Community Action Team to implement recommendations with the goal of reducing disparity in American Indian infant deaths and decreasing LBW.

Staff provides resources to WIC staff on interventions to promote smoking cessation during pregnancy and postpartum reduction of secondhand smoke exposure. Both of these are strategies to reduce LBW, SIDS, and other smoking-related complications.

The 2nd preconception conference, sponsored by MDH, the March of Dimes, local public health, the University of Minnesota, and a health plan, drew 138 attendees. The focus of the conference was "Reaching Underserved Populations." One session featured a viewing of "When the Bough Breaks" with a facilitated discussion of the impact of LBW and prematurity on populations of color and infant mortality.

Staff does trainings on implementing the "5 A's" best practice intervention for smoking cessation in pregnancy with Positive Alternative grantees and public health nurses from multiple greater Minnesota counties. The training includes education on the impact of smoking on the woman's health, on the pregnancy outcome, and on the infant (and other children) after the birth. Each participant receives a toolkit with resources and simple strategies to overcome resistance to cessation and staying quit as well as encouraging reduction of secondhand smoke exposure for pregnant women, infants and children.

c. Plan for the Coming Year
Plans are to continue all activities described above. Title V staff will continue to expand and integrate Title V activities with the Office of Minority and Multicultural Health activities, especially efforts to eliminate the disparity in infant mortality and low birth weight among populations of color and American Indians.

Title V staff is collaborating with several other partners described above to plan the third annual Preconception Conference to be held in October 2009. This conference will be conducted by interactive video conference to acknowledge and accommodate budget restrictions for local public health and community-based programs that limit travel and conference registrations. There will be no fee to attend. The focus will be on reaching more providers from greater Minnesota with messages on providing ongoing primary health care to women of childbearing age to promote both women's health and healthy birth outcomes.

State Performance Measure 9: *Percent of Children and Youth with Special Health Care Needs (CYSHCN) with one or more unmet needs for specific health care services.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			14.1	10	12
Annual Indicator	14.1	14.1	12.9	12.9	12.9
Numerator	21685	21498	22967	22967	22967
Denominator	153795	152468	177669	177669	177669
Data Source					SLAITS
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	12	11	11	10	10

Notes - 2008
data source: National Survey of CSHCN 2005 / 06

Notes - 2007
2007 data not yet available

Notes - 2006
The 2006 data are not yet available.

a. Last Year's Accomplishments
This measure specifically addresses access to a medical home, oral health, specialty care and the organization of services.

There is professional consensus that children with a medical home are more likely to have their need for services met across all systems than are children without a medical home. Establishing, spreading and sustaining the concept of medical home in Minnesota is the primary activity used to address this performance measure. Medical Home Learning Collaborative teams were first established in Minnesota in 2004 through a MCH Bureau Medical Home grant (2002-2005). A subsequent MCH-B grant, the New Freedom Initiative (NFI) grant (2005-2008), that had as its goal the integration of the MCHB's six CSHCN core outcomes within the context of the medical home continued that collaboration. The 2007 Legislature appropriated funds to continue the collaborative through 2008 and ending in June of 2009. The 2008 Legislature created the concept of health care homes for patients of all ages enrolled in the state's publicly funded programs, state employees and fully-insured plans.

Funds from the 2007 legislative appropriation supported collaborative learning sessions that were held in January, April, and September of 2008. Curricula included Parents and Patients as part of the Care Team, EMRs, IEPs, strategies for billing for medical home activities, web resources, the Medical Home Index tool, the Chronic Care Model, the Model for Improvement, care coordination, data collection, specialist-primary care practitioner interaction and transition.

In addition to the medical home activities, the MCSHN section is collaborating with key stakeholders to implement a quality improvement project called the EHDI Community Collaborative. The aim of this collaborative is to improve the health and well being of children with permanent hearing loss and their families through enhancing capacity and coordination of public health, education, social service and parent-to-parent support systems to create and sustain effective community based systems of care. Staff also participated in the second NICHQ sponsored national collaborative on Epilepsy and Newborn Hearing Screening and representatives from the Minnesota team were asked to serve as faculty for the third collaborative which began in June.

The CYSHCN program continues to partner with the Children's Mental Health Services Division at the Minnesota Department of Human Services (DHS) to provide statewide trainings on the DC: 0-3™ diagnostic criteria as a method to increase local capacity of mental health professionals for

service provision to young children. DC: 0-3™ is a taxonomy that allows a more child friendly diagnostic classification system that can be converted to the DSM-IV classification system for purposes of reimbursement thereby decreasing financial barriers to mental health services. To date, 2,500 professionals have been trained in the diagnostic criteria specifically and infant mental health generally.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide TA to Medical Home Teams		X		X
2. Continue support of mental health activities and initiatives underway		X		X
3. Continue support of interagency planning at the individual level				X
4. Continue operation of MCSHN clinics located in underserved areas of the state	X			
5. Sponsor specialty healthcare regional conferences				X
6. Continue leadership role in health conditions and early intervention eligibility		X		X
7. Provide outreach to increase awareness of community-based resources among the health provider community		X		X
8. Continue the Take the Maze out of Funding workshops to inform families, community agencies and health care providers of resources available.		X		
9. Assist in the implementation of Health Care Home legislation.	X	X	X	X
10. Work with Children's Hospital to analyze reimbursement for hospice and palliative care				X

b. Current Activities

2008 legislation required standards be developed for voluntary certification of primary care practices as health care homes beginning in July of 2009. Development of these standards began in the fall of 2008 with the formation of a unit reporting to the Executive Office of MDH. The Title V program assisted this new unit throughout the year through support for a community-wide certification work group and by drafting RFPs to assess the capacity of the primary care system to implement health care homes.

Medical home collaborative learning sessions continued to be held and were done so in conjunction with the EHDI collaborative learning sessions. The CYSHCN program continues to maintain and staff a toll-free phone line giving families and providers access to information regarding services and resources in their communities. The program continued to promote and support DC: 0-3™ trainings.

There was a considerable amount of Title V time devoted to autism in the Somali community because of a high rate of Somali children in Minneapolis school special education programs. While most of this activity was focused on prevalence and incidence issues, a one-day forum for Somali parents, educators and providers on linking community resources with Somali families was sponsored by Title V. One result of the above activity was a decision to initiate learning collaborative on autism and other developmental disabilities that will begin in September of 2009.

c. Plan for the Coming Year

The MCSHN Information and Assistance (I and A) program will continue to work closely with the Birth Defects Information System providing follow-up services to families of children with birth

defects assuring access to information regarding health care services and financing. It will also continue to field calls from families and professionals seeking health care resources for CYSHCN.

Further analysis and dissemination of I and A program data will be a priority. In addition to the toll-free number, efforts focusing on the availability of web-based information will continue. Through the MCSHN web-pages, families currently have access to information on financial and other resources, health conditions, early intervention, transition issues, emergency planning, medical home and data and reports.

The collaboratives for EHDI as well as autism and other developmental disabilities will be held. The EHDI collaborative will attempt to enroll additional teams participating in that activity. The autism and other developmental disabilities collaborative plans to recruit up to ten practice teams to participate in the collaborative. This recruitment will begin in the fall of 2009 and the first learning session will be held in late fall of 2009 or early in 2010. One of the objectives in this collaborative will be the development of a mental health index tool for primary care practices to use as a resource, modeled after the medical home index tool.

The MDH will begin voluntary certification of medical practices as health care homes. Title V will provide technical consultation and assistance to those practices seeking certification and requesting assistance from the department.

Title V works quite closely with colleagues from the state's Medicaid program. The Medicaid program has responded to the ABCD-III RFP from the Commonwealth Fund for proposals to create more efficient linkages to support healthy child development. If funded, Title V will work closely with Title XIX to implement the grant's objectives.

State Performance Measure 10: *Degree to which comprehensive mental health screening, evaluation, and treatment is provided to Children and Youth with Special Health Care Needs (CYSHCN).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			7	8	9
Annual Indicator	5	6	7	9	11
Numerator	5	6	7	9	11
Denominator	20	20	20	20	20
Data Source					MCSHN staff
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	12	12	13	13	14

Notes - 2006
Actual scale score is 6.5

a. Last Year's Accomplishments
This state performance measure examines the state's progress in relation to a mental health system (screening, evaluation and treatment) for CYSHCN.

The state CYSHCN program continues to work closely with Children's Mental Health Services (CMHS) of the Minnesota Department of Human Services. CMHS was one of five grantees in the Assuring Better Child Development-II (ABCD-II) grant activity funded by the Commonwealth Fund and administered by the National Association of State Health Policy (NASHP). Minnesota's objectives included supporting primary care provider efforts to meet the needs of children at risk

for delay in social or emotional development that do not meet the criteria for receiving services from the existing children's mental health system. The CYSHCN program collaborated with the CMHS program through financial and staff support of DC:0-3 trainings.

MCSHN district staff and CMHS regional staff met periodically to discuss issues surrounding service availability and planning within respective regions. Quarterly regional staff meetings include Medicaid Home and Community Based Waivered Services staff, CMHS and MCHSN staff who identify resource issues, gaps in services and develop plans that can be implemented at the regional level to address the availability of appropriately trained and supervised behavioral aides for children and their families.

MCSHN focused its efforts on logistical support of DC 0-3 trainings, integrating mental health curricula into medical home learning sessions and the operation of Development and Behavior Clinics. These clinics provide a one-day, multidisciplinary team diagnostic assessment of children up to the age of 21. The children referred have multiple behavioral, developmental, educational and physical issues. Most referrals originate from schools districts of less than 2000 total enrollment, most children are five to nine years of age and most have private insurance.

The Minnesota Department of Education (MDE) is the lead state agency for implementation of Part C in Minnesota. Through an interagency agreement, the CYSHCN program is responsible for the child find outreach activities pursuant to Part C requirements. One of the ways this has been fulfilled is through the local Follow Along Program (FAP). The Ages and Stages Questionnaire (ASQ) is the screening tool used by the FAP. Staff provided training and consultation to local agencies on the FAP and administration of the ASQ-SE. Over 600 professionals and paraprofessionals were trained in the administration and scoring of the ASQ and ASQ-SE in this last year. Sixty FAPs have now integrated the Social/Emotional component of the ASQ into their programs .

The Medical Home Collaborative learning sessions included enhancing collaboration between primary care and specialty providers with the identification of specific strategies that can be employed by primary care practitioners. In addition to an in-depth discussion of the new Bright Futures, one learning session was dedicated to mental health topics in primary care. Plenary and breakout sessions included incorporating developmental and mental health screening into the primary care visit, caring for every child's mental health in primary care, an introduction to the ASQ-SE and the Follow-Along Program and how that program relates to primary care and the medical home.

Six (6) Minnesota Initiative Foundations launched a statewide effort to help communities support the healthy social and emotional well-being of young children. Known as the Minnesota Thrive Initiative, CYSHCN regional staff members participated in the planning for pilot sites and provided technical assistance and consultation to the area action teams.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue collaboration with Children's Mental Health Services (CMHS) of the Minnesota Department of Human Services.				X
2. Continue logistical support for DC:0-3™ trainings throughout the state.				X
3. Continue supporting CMHS in its implementation of the Commonwealth Fund's ABCD-II grant.				X
4. Support regional trainings and workshops.				X
5. Continue to promote universal implementation of the ASQ and ASQ-SE.	X		X	

6. Continue to promote interagency coordination of services.				X
7. Continue to conduct MCSHN Development and Behavior Clinics.	X			
8. Implement recommendations on autism.				X
9.				
10.				

b. Current Activities
Administrative and training activities continue through the Follow-Along Program, use of the ASQ screening tool and its social-emotional component, the ASQ-SE. The state Medicaid program contracts with the Title V program for CTC (EPSDT) trainings for local public health agencies and these trainings now include training on the ASQ and ASQ-SE screening tools as well. Staff facilitated capacity building around infant and early childhood social-emotional issues.

MCSHN is on the steering committee for Minnesota Association for Infant and Early Childhood Mental Health (MAIECMH), a consortium of groups that developed standardization and credentialing of infant mental health providers. Staff also serve on the statewide Thrive Initiative and continue to serve on the ABCD steering committee.

The Development and Behavior clinics continue. Collaboration with CMHS and DC 0-3 statewide trainings continue, reaching a total of slightly more than 2,500 mental health and early childhood professionals over the last three years. An increased emphasis on autism resulted in a report on the administrative prevalence of Somali children in Minneapolis special education programs.

c. Plan for the Coming Year
Title V will utilize a collaborative learning model to address issues presented by autism. This approach will employ learning sessions and partnerships with the state AAP Chapter, the state's LEND grantee, the Governor's Council on Developmental Disabilities and Children's Mental health Services. Staff will work their MCH counterparts to implement strategies recommended by the mental health workgroup of the MCH Task Force. Collaboration with the Department of Human Services at the state and regional level through the support of CMHS in its ABCD-II activities and financial and administrative support of DC: 0-3 trainings will continue. Trainings are expected to include a repeat of the previous offerings as well as advanced curricula for individuals who desire a more indepth knowledge and understanding of interventions to promote the social-emotional health of young children.

Local capacity building initiatives such as regional mental health needs assessment and planning, consultation and technical assistance in the area of mental health continue. Support planning and implementation of efforts addressing the availability of appropriately trained and supervised behavioral aides for children and their families. MCSHN district staff will work in collaboration with CMHS regionally assigned staff to promote the development and implementation of models of co-location of health and mental health staff, quality improvement models that include telemedicine or other methods of psychiatric consultation to pediatric and family practice physicians in the far reaches of Greater Minnesota and models of service delivery for young children and their families that promote cross agency collaboration in rural areas where both population and services are sparse. State staff will continue to offer ASQ/ASQ-SE training for early childhood personnel.

E. Health Status Indicators

Introduction
The health status indicators tracked and reported in this document contribute to the ability of the Title V programs to provide the most recent information on state residents, which is subsequently

use in applying for grants, setting Title V program priorities, and outlining major issues of concern. Further, these indicators clarify areas of need and areas of achievement, which assists in determining areas of possible focus for the upcoming five-year Needs Assessment.

Data on infant birth weight can be viewed in its own right and/or correlated with corresponding data on infant death, age of mother and race/ethnicity. Trends revealed by these cross-tabbed analyses serve to assist in directing efforts towards those populations most likely to benefit from public health outreach or targeted interventions. Community education, innovative clinic programs, and other proactive interventions can and do benefit from this information.

Of particular interest and utility is the cross-agency data which we obtain from the Minnesota Department of Human Services (e.g., Medicaid data, TANF families, single parent households, foster home care), as well as the Minnesota Department of Education (high school dropout rate) and the Department of Corrections (juvenile crime rate). The data collected and the monitoring carried out by these agencies combines well with our public health data and gives it greater depth and meaning.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	6.6	6.6	6.6	6.8	
Numerator	4645	4685	4709	4982	
Denominator	70614	70899	71344	73651	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008
2008 natality data not yet available.

Notes - 2007
2007 data not yet available

Notes - 2006
The 2006 data are not yet available.

Narrative:
/2010/HSI 01 A-B and 02A-B: Low and Very Low Birth-weight Births

Minnesota has met its overall benchmarks regarding infant birth weight quite consistently throughout the past decade. The percent of very low birth-weight births (infants weighing less than 1500 grams) has remained constant since 2001, varying by only .1% for both singleton and multiple births (.9 to .8%, singleton; 1.1 to 1.2%, multiple). A gradual but very slight rise has been seen in low birth-weight births (infants weighing less than 2500 grams) during this time, with an overall increase of .5% or less (4.6 to 5.0%, singleton; 6.3 to 6.8%, multiple).

In our most recent year's data (2007) the proportion of live births weighing less than 1500 grams was 1.2 percent, with singleton births under 1500 grams at 0.8 percent. Also in 2007 the proportion of live births weighing less than 2500 grams was 6.8 percent, while singleton births under 2500 grams were at 5.0 percent. These discrepancies are extremely small and can be attributed to normal annual variations.

A factor of greater concern is the large number of White births in Minnesota, compared with a much smaller number of births to non-White and Hispanic persons, largely due to their lower percentage in the overall population. This unequal distribution tends to conceal the inherent disparities in birth outcomes, which are often less positive for minority populations. One of the initiatives we developed to address birth outcomes is a series of three preconception/interconception conferences directed towards educating persons living and working in communities of color and high poverty. We are in our third year of this initiative and have had very positive feedback from providers as well as community members.//2010//

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	4.9	4.9	4.9	5.0	
Numerator	3324	3339	3470	3543	
Denominator	68112	68402	70816	71102	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008
2008 natality data not yet available.

Notes - 2007
2007 data not yet available

Notes - 2006
The 2006 data are not yet available.

Narrative:
/2010/ See combined narrative under HSI #01A.//2010//

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1.2	1.2	1.2	1.2	
Numerator	821	884	856	898	
Denominator	70614	70899	71344	73651	

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008
2008 natality data not yet available.

Notes - 2007
2007 data not yet available

Notes - 2006
The 2006 data are not yet available.

Narrative:
/2010/ See combined narrative under HSI 01A.//2010//

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	0.9	0.9	0.9	0.8	
Numerator	586	636	632	599	
Denominator	68112	68402	70416	71002	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008
2008 natality data not yet available.

Notes - 2007
2007 data not yet available

Notes - 2006
The 2006 data are not yet available.

Narrative:
/2010/ See combined narrative under HSI 01A.//2010//

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	9.2	7.4	6.9	7.1	
Numerator	95	74	71	73	
Denominator	1030130	1005572	1030354	1035153	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008
2008 injury data not available yet.

Notes - 2007
2007 data not yet available

Notes - 2006
The 2006 data are not yet available.

Narrative:
/2010/ HSI 03 A-C: Fatal Injuries

As a whole, the death rate due to unintentional injuries among children ages 14 years and younger has fluctuated over the past six years, declining from a high of 10 per 100,000 children in 2002 to a low of 6.9 in 2006, with a spike upwards to 9.2 in 2004. Outcomes from 2007 (7.1/100,000) are slightly higher (.2) but still consistent with 2006 data.

Within that same age group, the death rate due to motor vehicle crashes continued to decline this year, from a high of 4.2 per 100,000 children in 2002 to 2.2 in 2006 and a new low of 1.9 in 2007. This downward trend can be attributed in part to increased seat belt use for younger children, as well as increased enforcement of the seat belt law in MN.

In addition, MDH has been working to upgrade its data collection procedures over the past three years (since 2005). Improved understanding and interpretation of injury outcomes reflect this effort. Coordinated procedures for entering and managing hospital discharge data have reduced duplication and errors in both diagnostic codes and e-codes. Thus, the validity of reported data is based on higher standards. It is expected that MCH data quality will continue to advance in the next few years as our data systems are upgraded and further refined.

For older youth and young adults ages 15 through 24 years, the data also show a decrease in deaths due to motor vehicle crashes from 20.5 per 100,000 youth/young adults in 2006 to 19.4 in 2007. As might be expected, however, the death rate from motor vehicle accidents is greater for this age group (ten times higher) than for those under age 15, due to greater access and use of motorized vehicles (19.4 compared with 1.9). Even so, the motor vehicle death rate in this age group has been declining consistently since reaching a high of 25.0/100,000 in 2003.//2010//

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	3.4	2.4	2.2	1.9	
Numerator	35	24	23	20	
Denominator	1030130	1005572	1030354	1035153	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008
2008 injury data not available yet.

Notes - 2007
2007 data not yet available

Notes - 2006
The 2006 data are not yet available.

Narrative:
/2010/ See combined narrative for fatal injuries under HSI 03A.//2010//

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	20.0	18.8	20.5	19.4	
Numerator	150	142	153	142	
Denominator	749353	757328	746654	732526	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008
2008 injury data not available yet.

Notes - 2007
2007 data not yet available

Notes - 2006
The 2006 data are not yet available.

Narrative:
/2010/ See combined narrative for fatal injuries listed under HSI 03A.//2010//

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	208.4	213.7	188.3	193.0	
Numerator	2147	2149	1940	1998	
Denominator	1030130	1005572	1030354	1035153	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008
2008 inpatient hospital discharge data will not be available until after 1/1/10.

Notes - 2007
2007 data not yet available

Notes - 2006
The 2006 data are not yet available.

Narrative:
/2010/ HSI 04 A-C: Non-Fatal Injuries

The overall rate of non-fatal injuries among children ages 14 years and younger has increased slightly this year (193/100,000 in 2007) compared with 2006 (188.3/100,000). This indicator took a sharp decline in 2006 after several years of mixed results.

Although it had been steadily declining since 2002, the rate of non-fatal injuries specifically due to motor vehicle crashes per 100,000 children in that age group is up from 14.2 in 2006 to 22.8 in 2007. The goal of this indicator is to reduce the number of hospitalizations of children age 14 years and younger due to non-fatal injuries; thus, Emergency Department-only admissions are not included in this measure. Nevertheless, the rate of non-fatal injuries requiring inpatient care due to motor vehicle crashes was noticeably higher in this age group during 2007 (22.8/100,000). Among older youth (ages 15-24) larger discrepancies were seen. The rate per 100,000 persons in this population increased from 80.9 per 100,000 youth in 2006 to 108.9 in 2007, after declining steadily since its peak in 2003 (111.0/100,000). Further review of the data will be needed to determine the cause of this reversal.//2010//

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	19.5	18.3	14.2	22.8	
Numerator	201	184	146	236	
Denominator	1030130	1005572	1030354	1035153	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008
2008 inpatient hospital discharge data (from hospitals participating in the MN Hospital Association) will not be available until at least January 2010.

Notes - 2007
2007 data not yet available

Notes - 2006
The 2006 data are not yet available.

Narrative:
/2010/ See combined narrative for non-fatal injuries listed under HSI 04A.//2010//

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	105.3	92.6	80.9	108.9	
Numerator	789	701	604	798	
Denominator	749353	757328	746654	732526	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2008
2008 inpatient hospital discharge data (obtained from hospitals participating in MN Hospital Association) will not be available at least until after January 1, 2010.

Notes - 2007
2007 data not yet available

Notes - 2006
The 2006 data are not yet available.

Narrative:
/2010/ See combined narrative for non-fatal injuries listed under HSI 04A.//2010//

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	15.5	17.1	17.5	18.3	19.6
Numerator	2834	3118	3205	3347	3578
Denominator	182828	182828	182828	182828	182828
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
/2010/ HSI 05 A-B: Chlamydia

Sexually transmitted diseases (STDs) reached an all-time high in Minnesota in 2006, with Chlamydia accounting for more than 75% of all STD cases in 2008. Reported cases continue to rise steadily across all ages, racial/ethnic groups and geographic areas. Since 1996, the overall rate of Chlamydia has doubled among Whites, Hispanics, and Asians. Even greater increases are seen in the Black and American Indian populations. The most marked expansion is evident in the suburban metro area as well as outstate and rural MN.

While improved testing technology and screening practices, in addition to an active STD surveillance system, account for a large part of earlier increases, recent growth is also driven by an actual increase in this infectious disease through increased transmission. An expanded state population also contributes to the number of Chlamydia cases in MN.

The rate of Chlamydia for young women ages 15 through 19 years of age was 19.6 cases per 1,000 women in that age group during 2008, up from 18.3 the previous year and 15.5 in 2005. These rates mirror trends at the national level, which have doubled over the last decade. An increased rate was also seen in women ages 20 through 44 years, with 7.2 cases per 1,000 women in that age range and 6.8 the previous year (2007), up from 4.9 in 2002. While both age groups have seen parallel rate increases, it is the adolescent females (ages 15-19) who have the larger raw numbers (2-3 times the rate of older women) and for whom this highly contagious infection is of greatest concern. //2010//

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	5.8	6.2	6.5	6.8	7.2
Numerator	5254	5603	5868	6118	6462
Denominator	899814	899814	899814	899814	899814

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2006
The 2006 data are not yet available.

Narrative:
/2010/ See combined narrative listed under HSI 05 A. //2010//

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	72843	62383	5785	1074	3601	0	0	0
Children 1 through 4	281058	233310	26764	5183	15801	0	0	0
Children 5 through 9	334522	285088	26778	5541	17115	0	0	0
Children 10 through 14	346730	298617	24802	5669	17642	0	0	0
Children 15 through 19	371683	324586	24160	6689	16248	0	0	0
Children 20 through 24	360843	319654	21279	6129	13781	0	0	0
Children 0 through 24	1767679	1523638	129568	30285	84188	0	0	0

Notes - 2010

Narrative:
/2010/ HSI 06 A-B: Population Demographics by Age Group and Race/Ethnicity

Population estimates for 2007, enumerated by sub-populations of age group and race/ethnicity, were provided by the U.S. Bureau of the Census. According to these projections, the group of infants, children, teens and young adults ages 0 to 24 years accounts for 34% (1,767,679) of the total population (5,197,621) in Minnesota, which is almost identical to the previous year's proportion (35%). Infants, children and teens ages 0 to 19 years comprise 27% of the total population, or 371,683 persons. With respect to race, population estimates indicate that 86% of all MN infants, children, teens and young people are White, 7% are Black, 5% are Asian, and 2% are American Indian. An estimated 6% of these individuals are Hispanic.

The statistics cited above suggest that Minnesota's population demographics have

changed very little in the past few years, although there has been a trend towards a slow but ever-increasing non-White population over the past decade or more. Given that these data are projections only, little can be said about concrete changes in demographics since the decennial census of 2000. However, it is clear that there continues to be greater diversity in MN, and with this diversity, increasing challenges for Title V programs to introduce culturally appropriate strategies that target the varied set of needs appropriate for this growing segment of our population. //2010//

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	67159	5684	0
Children 1 through 4	258934	22124	0
Children 5 through 9	311763	22759	0
Children 10 through 14	327282	19448	0
Children 15 through 19	355920	15763	0
Children 20 through 24	344723	16120	0
Children 0 through 24	1665781	101898	0

Notes - 2010

Narrative:
/2010/ See combined narrative on population demographics listed under HSI 06A.//2010//

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	67	22	18	7	5	0	0	15
Women 15 through 17	1519	672	320	120	143	0	0	264
Women 18 through 19	3663	2186	589	228	253	0	0	407
Women 20 through 34	57713	43863	4939	1059	3868	0	0	3984
Women 35 or older	10708	8583	793	102	702	0	0	528
Women of all ages	73670	55326	6659	1516	4971	0	0	5198

Notes - 2010

Narrative:
/2010/ HSI 07 A&B: Live Births

Live births in the state of Minnesota increased from 73,515 total births in 2006 to a total of 73,670 infants in 2007, an overall increase of only 1%. In 2006, the overall increase was 3.5%. As might be expected, the largest number of births occurred to women between the ages of 20 through 34 years, both overall as well as across all racial and ethnic categories. Women in this age group had approximately five times the number of births as any other age category. More than three-quarters of all 2007 births (78-79%) occurred to women between ages 20 through 34 years.

Women age 35 or older had the second highest number of births, accounting for approximately 15% of all infants born in 2007, more than twice the percentage of young women giving birth. Teens and younger women under the age of 20 account for the remaining 7% of 2007 births in MN. Similar age patterns were noted in 2006. These statistics may be indicative of a statewide trend to delay childbearing beyond the early working years, particularly among MN's sizeable White population as well as the much smaller Asian population. The same trend was not observed in the Black population or among Hispanics or Native Americans, where teen births were the second highest age category, accounting for 14% (Blacks and Hispanics) and 23% (Native Americans) of 2007 births, respectively.

Because young girls in their teens give birth to low birth-weight (< 2500 gms.) and very low birth-weight (< 1500 gms.) babies with greater frequency than women in their 20s or older, the high proportion of such births within the Black, Hispanic, and American Indian communities is of considerable concern. In addition, young teens often do not have adequate prenatal care and are especially vulnerable to complications of pregnancy and childbirth. Minnesota teens need increased intervention to address these issues, particularly among racial/ethnic groups with the highest proportion of young births.//2010//

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	47	18	2
Women 15 through 17	1169	322	28
Women 18 through 19	3133	498	32
Women 20 through 34	52465	4517	731
Women 35 or older	10015	554	139
Women of all ages	66829	5909	932

Notes - 2010

Narrative:
/2010/ See combined narrative for Live Births under HSI 07 A. //2010//

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	407	264	81	18	24	0	0	20
Children 1 through 4	64	46	7	3	4	0	0	4
Children 5 through 9	39	27	6	0	4	0	0	2
Children 10 through 14	44	34	5	3	1	0	0	1
Children 15 through 19	161	133	9	8	7	0	0	4
Children 20 through 24	270	213	31	8	10	0	0	8
Children 0 through 24	985	717	139	40	50	0	0	39

Notes - 2010

Narrative:
/2010/ HSI 08 A&B: Deaths of Infants and Children

An overall total of 985 deaths of infants, children, and youth ages 0-24 occurred during 2007, almost identical to the number of deaths in 2006 (N = 986). The greatest proportion of those deaths (41.3%) occurred to infants less than one year of age. In 2007, the number of child deaths prior to age one was 407 for all racial/ethnic groups, compared with 414 in 2006. Minnesota's infant mortality rate (0 to age 1) has remained quite stable over the past few years with 5.1 deaths per 1,000 live births in 2005, 5.2 in 2006, and 5.5 in 2007.

The second largest proportion of deaths (27.4%) in 2007 occurred in the young adult population between 20-24 years, with an outcome which is very similar to 2006 (26.2%). This group when combined with teens age 15-19 accounts for 43.8% of all 2007 deaths for persons 0-24 years. It is important to address individuals in this age range (15-24 years) with new and innovative interventions because many of these deaths are due to preventable injuries such as motor vehicle crashes, suicides, and drug/alcohol related issues which frequently occur during these years.

Regarding racial/ethnic distribution, the majority of deaths for all non-White populations in 2007 occurred in the 0-1 age group. More than half (58.3%) of all Black child deaths occurred prior to one year of age. Similarly, 53.3% of Hispanic deaths, 48.9% of Asian deaths, and 45% of American Indian child deaths occurred in the first twelve months of life (0-1 year). In contrast, only 36.8% of White infant deaths took place before their first birthday. For White children/youth in MN, the highest death rates occurred during the teen and young adult years (ages 15-24) where 48.3% of deaths occurred. It would appear that different strategies need to be used in addressing these divergent outcomes and populations. //2010//

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	366	32	9
Children 1 through 4	54	7	3
Children 5 through 9	35	2	2
Children 10 through 14	41	3	0
Children 15 through 19	155	6	0
Children 20 through 24	258	10	2
Children 0 through 24	909	60	16

Notes - 2010

Narrative:
/2010/ See combined narrative for Deaths of Infants and Children listed under HSI 08A. //2010//

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	1406836	1203984	108289	24156	70407	0	0	0	2007
Percent in household headed by single parent	20.9	17.3	62.3	62.0	16.0	0.0	72.6	31.8	2007
Percent in TANF (Grant) families	5.8	2.8	31.0	31.0	10.6	0.0	0.0	0.0	2007
Number enrolled in Medicaid	412416	225740	83856	17693	28181	362	14982	41602	2008
Number enrolled in SCHIP		0	0	0	0	0	0	0	2008
Number living in foster home care	14800	7770	3071	1816	333	6	1215	589	2007
Number enrolled in food stamp program	239923	112712	68956	14965	19098	241	23951	0	2008
Number	172156	102218	28860	11329	11982	320	17442	5	2008

enrolled in WIC									
Rate (per 100,000) of juvenile crime arrests	3171.0	2382.0	11841.0	7845.0	1733.0	0.0	0.0	0.0	2007
Percentage of high school drop-outs (grade 9 through 12)	6.3	4.2	13.3	18.6	6.0	0.0	0.0	0.0	2007

Notes - 2010
MN Dept. of Education is currently transitioning from data based on the Graduation Completion Rate to the recently-adopted National Governors' Association (NGA) rate system. Thus, next year's dropout rates will be more accurate and more uniform across all states.

Narrative:
/2010/According to US Census Bureau estimates 1,406,836 infants and children ages 0 through 19 years lived in Minnesota during 2007. These numbers reflect a small increase of 3,763 children (< .3%) since 2006. Projection estimates also indicate that MN children are predominantly white (85.6%) with 7.7 % Black, 5% Asian and 1.7% American Indian; 6.1% identify as Hispanic. This distribution is nearly identical to the previous year (2006).

As indicated in the Census, 21% of children and youth 0-19 years were living in households headed by single parents in 2007. This percentage varied considerably by race. Nearly two-thirds (62%) of Blacks and three-fourths (73%) of multi-racial children lived in single-parent households, while only 17% White and 16% Asian children lived in this type of family. According to the MN Department of Human Services (DHS) there were 14,800 children in out-of-home placements, 55-60% of whom were in foster home care. More than half were White (53%), 21% Black, and 12% American Indian.

According to DHS data, 5.8% of children ages 0-19 years lived in families receiving TANF grants during 2007; 29.3% were enrolled in Medicaid. These percentages are almost identical to the previous year (2006). There were clear differences between racial/ethnic groups. Thirty-one percent (31%) of both Blacks and American Indian children lived in TANF families, while 12% of Hispanics, 10% of Asians, and 3% of Whites lived in such homes. Roughly three-quarters of Black (77%) and American Indian (73%) children and more than half of Hispanics (58%) were enrolled in Medicaid during 2007 while only 40% of Asians and 19% of White children received such assistance.

The food stamp program enrolled 239,923 individuals or 17% of children ages 0-19 years. White children received 47% of all food stamps, reflecting their primacy in the population, while Blacks received 29%. The balance of food stamp recipients were divided between American Indians, Asians and persons of mixed racial background. WIC enrolled 172,156 children under age five. Fifty-nine percent (59%) of children receiving nutrition services from WIC were White; 16% Black, 7% Asian, 7% American Indian and 10% mixed racial heritage; 38% of the Hispanic population also received WIC services, a positive sign.

Juvenile crime statistics in 2007 show an overall rate of 3171 arrests per 100,000 juveniles under age 19, down from 2005-06. Blacks continue to lead with an arrest rate of 11,841 per 100,000 juveniles, nearly five times higher than the White rate. American Indians are second at 7845. Asians have the lowest rate of arrests (1,733) with Whites at 2,382/100,000. On a parallel track the percentage of high school dropouts continues to decline among the

White population and increase among non-White teens. If this trend continues, we are not likely to see abatement of non-White juvenile crime, as education is a primary factor in providing quality jobs and positive activities for young people.//2010//

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	1321058	85778	0	2007
Percent in household headed by single parent	0.0	33.0	0.0	2007
Percent in TANF (Grant) families	5.8	12.2	0.0	2007
Number enrolled in Medicaid	357478	50144	4794	2008
Number enrolled in SCHIP	0	0	0	2008
Number living in foster home care	13563	1237	0	2007
Number enrolled in food stamp program	213029	26894	0	2008
Number enrolled in WIC	139634	32517	5	2008
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	0.0	2007
Percentage of high school drop-outs (grade 9 through 12)	85.6	14.4	0.0	2007

Notes - 2010
2008 data not yet available.

MN Bureau of Criminal Apprehension (BCA) Uniform Crime Report does not separate juvenile crime from adult crime by ethnicity, only by race.
2008 data not yet available.

2008 data not yet available.

MN Bureau of Criminal Apprehension (BCA) Uniform Crime Report does not separate juvenile from adult crime by ethnicity, only by race.

MN Dept. of Education is currently transitioning from data based on the Graduation Completion Rate to the recently-adopted National Governors' Association (NGA) rate. Thus, next year's dropout rates are expected to be more accurate as well as more uniform across all states.

2008 data not yet available.

Narrative:
/2010/ See combined narrative listed under HSI 09A.//2010//

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	**Total**

Living in metropolitan areas	703008
Living in urban areas	336558
Living in rural areas	367270
Living in frontier areas	0
Total - all children 0 through 19	703828

Notes - 2010
Refers to seven-county metro area surrounding and including St. Paul and Minneapolis.

Refers to urban areas other than Minneapolis-St. Paul, specifically the cities of Duluth, Rochester, St. Cloud, Mankato, and Moorhead.

Rural areas include all areas of the state not covered by the 7-county metro area of Minneapolis-St. Paul or the other urban areas of the state which contain smaller cities.

There are no frontier areas in MN.

Narrative:
/2010/ HSI 10: State Demographic Data: Geographic Living Area

The American Community Survey estimates Minnesota's total population as 5,197,621 persons in 2007, an increase of 177,901 residents, or 3.4%, over the past five years. Despite the fact that many states and metro areas have experienced decreased population in recent years, MN continues to attract new residents. Much of this increase has occurred among populations of color and diverse ethnicity, specifically Hispanics, Hmong, Somalis, Liberians, and Asian Indians. The bulk of our new arrivals have remained in the seven-county metro area surrounding Minneapolis and St. Paul, which reflects the greatest diversity and the lowest percentage of White residents across the state (85.1%), with 8.1% Black, 5.8% Asian, and 1.0% American Indians. In addition, more than two-thirds of the Hispanic population in MN (196,135) resides in the metro area.

Geographic distribution shows that 703,008 persons, or 50% of Minnesota's population, live in the seven-county metropolitan area surrounding and including the cities of St. Paul and Minneapolis. Additional urban areas (Duluth, Rochester, St. Cloud, Mankato, and Moorhead) account for 336,558 citizens, or 23.9% of the state's population. The balance of MN residents, 367,270 or 26.1%, live in rural or semi-rural areas of various sizes throughout the state. //2010//

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	5197621.0
Percent Below: 50% of poverty	4.0
100% of poverty	9.3
200% of poverty	23.9

Notes - 2010

Narrative:
/2010/ HSI 11 & 12: State Demographic Data: Poverty Levels

It is estimated by the U.S. Census Bureau that 481,330 persons, or 9.3% of Minnesota's population, were living below 100% of the federal poverty level (FPL) in 2007, while 1,243,000 or 23.9% were 200% below FPL. A slightly higher percentage of children in both categories lived in poverty that year: 10.6% below 100% FPL and 25.0% below 200% FPL. There were 1,406,836 children ages 0 to 19 in 2007, equally divided between the seven-county metro area and "outstate" or Greater Minnesota. A small majority of children in poverty reside in the metro area (54%), compared with 46% in outstate areas.

Across the state, 15% of children under the age of five were living in poverty in 2006, reflecting a 35% increase between the years 2000-2006. During that same timeframe, there was a 30% increase in the number of MN families in poverty. For many children in these families, rising out of poverty will be very difficult and may result in significant health and social issues.//2010//

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	1406836.0
Percent Below: 50% of poverty	4.4
100% of poverty	10.6
200% of poverty	25.0

Notes - 2010

Narrative:
/2010/ See combined narrative on Poverty Levels listed under HSI 11. //2010//

F. Other Program Activities

/2010/ One of the Governor's early childhood initiative, Minnesota Parents Know, was funded by the 2006 Minnesota Legislature. The Department of Education hosts this interactive Website for parents in collaboration with the Departments of Health and Human Services. Other public and private partners include: University of Minnesota; Tufts University; Talaris Research Institute; Children's Hospitals and Clinics Warmline; New York University Child Study Center, University of Michigan Health System, Minnesota Parent Information and Resource Center; MN Parent Magazine as well as a number of others. This website provides up-to-date research-based information on children birth through grade 12, strategies to support children's learning, newsletters, expert tips, an interactive early childhood and child car search, connections to Minnesota services and resources, video clips, a parent Web literacy tutorial and customized search function of high quality, non-commercial child development and health websites. This site gets 10,000 hits per month.

A new section called Help Me Grow is expected to be released this fall. It will focus on child development (birth to age five), early intervention and special services for young

children. There will also be an online referral for parents, caregivers, health care providers and other service providers to be used when there are concerns about a child's growth, learning or development. Other web features will include brief developmental milestone videos and Watch Me Grow scrapbook for parents/caregivers/service providers/home visitors to document a child's progress and add photos/videos, if available. Responding to the new way of getting information the site will continue expansion in the years ahead.//2010//

Toll-free Telephone Numbers - For parents and others, the Minnesota Title V programs assure toll-free telephone access to information about health care providers and practitioners who provide health care services under Titles V and XIX SSA and about other relevant health and health-related providers and practitioners. MDH has worked to accomplish the intent of this requirement by improving the effectiveness of previously established special purpose toll-free arrangements.

1. The Title V CYSHN Program has operated a toll-free Information and Assistance telephone line since March of 1990. The toll-free number is 800 728-5420. This line offers a comprehensive listing of services provided by state and county health and human services departments, hospitals, associations, family support groups and allied public and private entities. The toll-free number is included on all educational and informational publications developed and distributed and is included in all media announcements. ***/2010/ Total calls to the CYSHN toll-free number in 2008 was 617.//2010//***

2. Minnesota does not have a dedicated 800 number for questions related to prenatal care or pregnancy. The Department of Human Services (DHS) consumer services call center 800 number handles questions related to obtaining prenatal care services from Medical Assistance or MinnesotaCare. Calls related to prenatal health programs and other maternal and child health matters are referred to Title V. Information regarding obtaining prenatal services and related questions can also be accessed via the MDH or DHS internet web sites.

3. The MinnesotaCare program provides an automated state toll-free line that operates 24 hours a day, seven days a week. The automated message is available in seven languages including Spanish, Hmong, Somali, Vietnamese, Laotian, Bosnian, and Russian. The number is (651) 297-3862 (metro) and 1-800-657-3672 (greater Minnesota). The toll-free number will provide the caller with general information about the plan, qualifications for acceptance, and application information. All outreach materials distributed by the Department of Human Services include this state toll-free number for clients to call with questions. The line handle about 200,000 calls per year.

4. The Minnesota Family Planning and STD hotline is staffed by individuals trained in information and referral as well as family planning and STD counseling. The number is 800-78-FACTS. Approximately 5,000 calls are handled by the hotline annually. All family planning and STD related educational materials distributed by the Minnesota Department of Health include the hotline number. Annually, a pamphlet about family planning, which includes the hotline number, is mailed to all Medicaid recipients. ***/2010/Family Planning hotline calls totaled 2,830 in state fiscal year 2008. Of these calls, approximately 15 percent were from individuals under age twenty and 48 percent were from individuals between the ages of 20 and 34. //2010//***

5. The WIC Program (Women, Infants and Children) 800 number is funded through Minnesota's federal WIC grant and provides 24 hour - 365 days a year phone coverage. Callers to the WIC 800 number are provided with the business telephone number of the local WIC project in their geographic area. The toll-free number is 800-WIC-4030. The service responds to approximately 3,300 calls per year. All WIC outreach materials distributed by the state WIC office and the local projects include the 800 number. There is also a WIC supported specialized line related to breastfeeding (877-214-BABY). ***/2010/ Currently approximately 800 calls a month or 9,600 a year are received.//2010//***

6. The Minnesota Immunization Hotline was established in 1994 and operates between the hours of 8:00 a.m. - 4:30 p.m. Monday through Friday. The toll-free number is 800 657-3970. The Hotline is staffed by a team of nurses and other professionals highly-trained in immunizations. Its primary purpose is to provide a timely source of information and consultation for providers and consumers faced with the increasing complexities of immunizations. /2007/ The Minnesota Immunization Hotline ended July 2, 2006. This decision was made in order to best use limited resources. Providers and patients with general immunization questions are referred to CDC INFO Contact Center. //2007//

G. Technical Assistance

Form 15 outlines the technical assistance needs identified by the Title V programs for the upcoming year. Additional discussions will be occuring internally to determine priorities, timing and suggested TA providers.

V. Budget Narrative

A. Expenditures

Please see Forms 3-5 and appropriate related notes.

B. Budget

V. Budget Narrative
A. Expenditures
Please see Forms 3-5 and appropriate related notes.

B. Budget
Oversight of the Title V, MCH Block Grant is the responsibility of the Division of Community and Family Health. The language in Minnesota Statutes Chapter 145.88 distributes two-thirds of Minnesota's federal MCH Block Grant funding (approximately $6.1 million) by formula to Community Health Boards (CHBs), Minnesota's local public health structure. The boards are comprised of elected officials, either county commissioners or city council members. They are responsible for policy formulation and oversight of the local public health administrative agencies which conduct core public health functions. State law requires CHBs to provide at least a 50 percent match for federal MCH Block Grant funds received each year. CHBs predominately use local tax dollars and some state grant dollars to meet their required match.

The legislation directs funding to be used for high risk and low-income individuals who 1) have a high rate of infant mortality and children with low birth weight, 2) target pregnant women who have an increased likelihood of complications during pregnancy, 3) address the health needs of young children who have or are likely to have a chronic disease or disability or special health need, 4) provide family planning services, 5) address the frequency and severity of childhood and adolescent health issues, 6) address preventing child abuse and neglect, reducing juvenile delinquency, promoting positive parenting and resiliency in children, and promoting family health and economic sufficiency through public health nurse home visiting and 7) address nutritional issues of women, infants and young children through WIC clinic services. The Division of Community and Family Health has responsibility to provide fiscal oversight and technical assistance to Community Health Boards in the use of these federal dollars.

CHBs are required to report annually on their expenditures of the federal MCH Block Grant. The approximately $6.1 million provided to the 53 CHBs represents approximately 2 percent of their total funding available for public health efforts. However, this percent of total funding is an average and does not reflect the wide variance between CHBs and their total budgets. The range of MCH Block Grant funding to their total funding is 2 percent to 16 percent, with the average being 5 percent. One issue with the distribution of a significant portion of the MCH Block Grant in this manner is that the 53 CHBs redirect these funds to where they are most needed to maintain core maternal and child health services. This causes a constant fluctuation in populations served, total numbers of individuals served, and type of services provided resulting in frequent changes in block grant data reporting greater than 10 percent.

State law allows one-third of the federal MCH Block Grant to be retained at the state to: 1) meet federal maternal and child health block grant requirements of a five year needs assessment and to prepare annual federal block grant applications and annual plans, 2) collect and disseminate statewide data on the health status of mothers and children, 3) provide technical assistance to CHBs, 4) evaluate the impact of maternal and child health activities on the health status of mothers and children, 5) provide services to children under age 16 receiving benefits under title XVI of the Social Security Act; and 6) perform other maternal and child health activities. Indirect charges for the total MCH Block grant are included in this portion of the funding.

Currently, the MCH Block Grant supports a total of almost 30 FTEs within the Division of

Community and Family Health, fifteen of which are located in the children and youth with special health needs program. The maternal and child health and children and youth with special health needs sections efforts are augmented with additional funding received from other federal grants (HRSA -- SSDI, Loss to Follow-up and SECS grants, CDC -- FAS, PRAMS and Preventive Block Grant funds directed at Suicide Prevention activities) and from various state (state general funds, newborn screening fees, marriage license fees, and Health Care Access Funds) and federal funds (Medicaid match and TANF funding as well as Department of Education Part C and Part B funding).

Other federal sources of funds that are administered by the Division of Community and family Health include Preventive Block Grant funds ($600,000) directed at providing public health technical assistance to CHBs and Department of Agriculture funds ($124,576,000 - which includes formula rebate funds) supports the WIC program, Commodity Food Supplemental Program and a small Breastfeeding Peer Support grant.

State appropriations used to support programs within the Division of Community and Family Health comes to over $32 million with the primary portion ($21 million) going to CHBs through the Local Pubic Health Grant. State funds support Division administration including the CYSHCN and MCH managers, family planning services, technical assistance to local CHBs, CYSHCN diagnostic clinics, FAS prevention, newborn screening follow-up and intervention, Women's Right to Know, Family Home Visiting program, Positive Alternatives Program, Suicide Prevention, infant mortality and technical assistance to local public health agencies.

The source of matching funds for the Title V Block Grant comes from both state and local sources. As mention earlier, CHBs are required to provide a 50% match for the federal Title V funding they receive. Additional federal match requirements are met by state funds administered by the Division of Community and Family Health that support MCH and CYSHCN program efforts. The largest of these efforts it the state funded Family Planning Special Projects Grants.

Minnesota's maintenance of effort from 1989 is $6,184,197. The budget documents that Minnesota continues to exceed this level of effort.

Additional program areas impacting the health of mothers and children, including children and youth with special health care needs located in other areas of the Minnesota Department of Health include: newborn screening program (Laboratory Division), reducing disparities in infant mortality (Office of Minority and Multicultural Health), lead screening and Birth Defects Registry (Environmental Health), Tobacco and childhood injury prevention (Health Promotion and Chronic Disease) and immunizations (Infectious Disease, Epidemiology, Prevention and Control Division). Funds supporting these programs are in addition to those outlined in this application. While Title V staff collaborates and work closely with these programs, no federal Title V funds are used directly to support these activities nor are any of these activities currently used to meet Minnesota's match or maintenance of effort.

Minnesota legislative activity impacting the Division include:

Significant changes in the budget occurred with the loss of Suicide Prevention Grant funding ($918,487) and the Dental Health Program ($100,000) in the 2005 Legislative session. However, during that same session the Department of Health was appropriated $50,000 in SFY 2006 and $2.5 million in SFY 2007 and thereafter for the Positive Alternatives Program. The primary goal of the program is to support, encourage, and assist a woman in carrying her pregnancy to term and caring for her baby after birth.

Budgetary changes made from the 2007 Legislative session impacting the Division of Community and Family Health included an additional $4 million allocation a year of TANF funds for the Family Home Visiting Program; an additional $1,156,000 dollars a year in TANF funding to replace reduced funding experienced in 2002 in the Family Planning Program; an additional $500,000 a

year in state funds for FAS prevention and intervention activities; $335,000 in the first year and $145,000 thereafter in state funds to reinstate some Suicide Prevention activities that were lost in the 2003 session; $1,000,000 in Health Care Access Funds for the next two years to expand the Medical Home Project currently underway in the CYSHCN program; and over $800,000 in fees and general fund appropriations to support Early Hearing Detection and Intervention Programs, including a Hearing Aid Loaner Bank and Family Support activities. The Division did see a reduction of $220,000 in state funds for the MN ENABL (abstinence education) Program.

/2009/ Budgetary changes made during the 2008 legislative session impacting the Division of Community and Family Health was the loss of the state funded abstinence education program and an across the board 1.8 percent reduction in funds available for the following grant programs: Local Public Health Act, Suicide Prevention, Positive Alternatives, Fetal Alcohol Syndrome Program, Hearing Aid Loaner Program and the Family Planning program. This equated to an overall budget reduction in the Division's grant programs of $754,000 beginning in state fiscal year 2009. The 2008 legislative session also provided approximately $1.1 million in additional funding for the next three years to the current budget of $500,000 to support Health Care Home (Medical Home) implementation. //2009//

/2010/ The 2009 legislative session provided additional funding for the Newborn Hearing Screening Program. Beginning in state fiscal year 2011, $223,000 will be available to provide support services for families with children who are deaf or have a hearing loss. The legislature directed this funding to a nonprofit organization that can provide statewide assistance to families with children who are deaf or have a hearing loss with direct parent-to-parent assistance and educational and medical options.

The Legislature and the Governor could not agree on how to respond to a projected $2.676 billion dollar biennial 2010-2011 budget short fall. Despite objections from the Legislature, the Governor decided to resolve the budget gap through the use of executive actions called unallotment and other administrative actions such as payment deferrals. The overall impact of unallotment was limited within the Department of Health, however an overall 8.2 percent ($2 million) general fund administrative reduction did occur and the impact of this reduction is not yet fully known//2010//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.